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Self-harm and Accident and Emergency (A & E)

Adult's perceptions of the Accident & Emergency experience of care following an act of self-harm; a systematic review

and

Reasons why men who present with self-harm leave Accident and Emergency before next care recommendations; An Interpretive Phenomenological Analysis (IPA)

Thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Clinical Psychology, in University College Cork

Donal Moynihan

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Supervisors: Dr Sharon Lambert and Daniel Flynn

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

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Adult's perceptions of the Accident & Emergency experience of care following an act of self-harm; a systematic review

Donal Moynihan[1], Dr Sharon Lambert[2], and Daniel Flynn[3]

[1,2]School of Applied Psychology, University College Cork

[3]Health Service Executive

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Abstract

Background

Self-harm is a major worldwide concern and research has demonstrated that 20-25% of individuals who die by suicide have engaged in an act of self-harm within the 12 months before their death. A & E proves to be a crucial entry point for the engagement with services for those who self-harm. However, experiences of care have been described in a negative light with Service Users reporting staff attitudes and behaviours to sometimes be 'ignorant' and 'punitive'.

Objective

This review aimed to synthesise the findings from qualitative and quantitative studies in order to understand how adults who self-harm experience care in A & E. In doing so, this review asks the following questions 'What is unhelpful about the care they received?' and 'What is helpful about the care they received?'

Method

A systematic literature search, in line with PRISMA guidelines, was carried out across five databases. 11 out of 1630 studies were included the final review, when inclusion criteria were applied. Findings from these studies were analysed using thematic synthesis.

Results

Four themes were identified which captured the experience of care; negative staff attitudes, an unsuitable physical environment, inner turmoil/ experience, and what is perceived as helpful.

Conclusions

It is evident that Service Users are dissatisfied with certain aspects of the physical environment and some staff attitudes. However, more research is necessary to explore alternative delivery systems and to assess feasibility.

Key words: Self-harm; Accident and emergency; emergency department; experience of care; systematic review

Introduction

Self-harm is a major worldwide concern (Murray et al., 2010) and Ireland is no exception (Perry et al., 2012; Griffin et al., 2017). Ireland had the 17th highest rate of death by suicide in EU member states in 2014 (Eurostat, 2017). Self-harming behaviours are not restricted to a certain demographic, but higher rates have been found among individuals who live alone, single, misuse alcohol, and are unemployed (Kendall, 2004; Corcoran et al, 2007). Difficulties in one's social network are often reported as precipitants to self-harm (Haw and Hawton, 2008; Middleton et al., 2004). Diagnostic criteria could be applied to these interpersonal difficulties. It has been found that up to half of individuals who attend Accident and Emergency (A & E) for self-harm could be classed as having a personality disorder (Haw et al., 2001). Although, this label can be perceived as unhelpful and may lead to increased stigma (Pembroke, 1994; Babiker & Arnold, 1997), which can inhibit help seeking (Fortune et al., 2008). There have been proposals to consider personality disorders more appropriately as a response to complex developmental trauma, which may decrease associated stigma (Spinazzola, van der Kolk & Ford, 2018; Ford, 2018).

There has been much research into the association between early trauma and future self-harming behaviours (Glassman, et al., 2007; Yates, Carlson, & Egeland, 2008). Multiples adverse childhood experiences (ACE's) have been found to be associated with an increased rate of adult self-harm and suicidal ideation (Felitti et al., 1998; Corcoran, 2006). Along with the heightened risk of self-harm, there is also an increase in the presentation of challenging behaviours when engaging with services (Lynch & Lambert, 2016). This is vital to consider when designing services for these individuals.

Research has demonstrated that 20-25% of individuals who die by suicide have engaged in an act of self-harm within the 12 months before their death (Hawton & Fagg, 1998; Bergen et al., 2010). Following the index episode, the rate of completed suicide has been found to be highest within the first 6 months (Cooper et al., 2005). However, a proportion of self-harm acts are not related to suicidal ideation (Swales, 2005). Research has shown that some individuals harm themselves as a means to manage unbearable emotional pain (O' Connor et al., 2009a). This can bring relief but is often associated with complex emotions such as shame (Chapman et al., 2006). How these difficult emotions are managed by clinical services is as important as the physical care needed. With multiple reasons and meanings of self-harm, those presenting to services can have varying expectations as to what encompasses good quality care.

The Accident and Emergency Department (A & E) proves to be a crucial entry point for the engagement with services for those who self-harm. There were 11,600 presentations to Irish hospitals following self-harm in 2017, making the national rate 199 per 100,000 (Griffin et al., 2018). Prevalence rate estimations of self-harm in community populations vary considerably. Nock et al. (2008) reported a 2.7% rate for 17 countries, with Italy (0.5%) at one end of the spectrum and the USA (5%) on the other. A UK study estimated the national rate to be between 4% and 4.5% for females and 3% and 4% for men (Bergen et al., 2010).

It is also estimated that those who present to hospital account for only a minority of individuals who self-harm (Royal College of Psychiatrists, 2010; Hawton et al., 2002). Those who self-harm are a vulnerable client group who remain hidden for the most part and an A & E presentation can be seen as a significant occasion for engagement and deploying suicide preventative measures (Royal College of

Psychiatrists, 2010). However, regardless of national guidelines (College of Psychiatrists of Ireland, 2016) for the management of self-harm, there remains commonplace frustration with services. Service Users criticize staff interactions due to perceptions of disrespect and misunderstanding, brought about by poor communication and involvement with their care (Owens et al., 2016).

The significance of a positive encounter with assessment and treatment cannot be emphasised enough, due to the heightened risk of suicide following self-harm (Bergen et al., 2010; Sinclair, Gray, & Hawton, 2006). Of those who present to A & E following an act of self-harm, many do not attend follow-up appointments, and more do not return for subsequent episodes of self-harm (Hunter et al., 2013). A community based study reported that less than 30% of their self-harming sample who had previous A & E attendances chose to present to the Emergency Department for subsequent incidents of self-harm (Guthrie, Kapur, Mackway-Jones et al. 2001). Experiences of care have been described in a negative light with Service Users reporting staff attitudes and behaviours to sometimes be ‘ignorant’ and ‘punitive’ (Owens et al., 2016). They also describe poor communication and understanding by healthcare professionals, along with feelings of being disrespected (Hunter et al., 2013; Horrocks et al., 2005; Palmer et al., 2007), which may reinforce shame and a felt sense of isolation. This further complicates the already difficult process of help-seeking after periods of emotional dysregulation.

Establishing a strong rapport with service users and encouraging collaboration, underpinned by empathy, is critical if additional intervention is to be offered (Royal College of Psychiatrists, 2010; Hunter et al., 2013). Other research has reported that staff can sometimes struggle to build this rapport due to conflicting perceptions of those who self-harm, resulting in detachment being used as a coping mechanism

(Chapman & Martin, 2014). They often report similar feelings of frustration and powerlessness (Rees et al., 2014; Karman, Kool, Poslawsky, & Meijel, 2015), which can result in a 'client blameworthy perspective' impacting on treatment (McHale & Fenton, 2010).

Although, there has been research on attitudes adolescents and adults hold toward multiple types of care for self-harm (e.g. inpatient, primary care, voluntary organisations, community counselling), to the author's knowledge this is the first systematic review looking specifically at the perception of the A & E experience by adults following an act of self-harm.

This review aims to synthesise the findings from a number of qualitative and quantitative studies in order to understand how adults who self-harm experience care in A & E. In doing so, this review asks the following questions

'What is unhelpful about the care they received?

What is helpful about the care they received?

For the purpose of the study self-harm will be defined as the following: 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences' (Platt et al., 1992, p. 99). This definition includes those who have self-harmed with avowed suicidal intent as well as those without.

Method

The structure of this review was conducted in accordance with PRISMA guidelines (2015).

Search Strategy

A literature search was carried out on the databases MEDLINE, PsychInfo, and CINAHL. OpenGrey and Google Scholar were also searched for grey literature. The reference sections of all included papers were also hand searched. The search was last conducted on 12th September 2018. The subject librarian at University College Cork was consulted to discuss possible search terms. There was not any date restriction. Databases were searched using the following terms:

("self-injury" OR "self-harm*" OR "self-cut*" OR “self-hurt*”OR "self-mutilate" OR parasuicide) AND ("Client Attitudes" OR "Client Satisfaction" OR "Client Participation" OR "Quality of Services" OR "Quality of Care") AND (‘Emergency Department’’ OR ‘‘Accident and Emergency’’ OR ‘‘A & E’’ OR ‘‘Emergency medicine’’ OR ‘’Urgent care’’) AND (‘Qualitative’ OR ‘Survey’ OR ‘Mixed Methods’)

Google scholar and OpenGrey were searched using the following terms:

(‘Self-Harm’ AND ‘Experience’) AND (‘Emergency Department’ OR ‘A & E’)

Inclusion Criteria

The following inclusion criteria was used in order to identify appropriate studies from the search:

(i) Adult sample (over 18 years of age)

(ii) Discusses experience of care in A & E following self-harm

Exclusion Criteria

(i) Sample under 18 years of age

(ii) Study was mainly discussing intellectual disability

(iii) The paper was not available in English

Eligible Studies

When duplicates were screened out using Mendeley reference manager, the titles of the remaining articles were reviewed, and the abstracts of potentially relevant articles were further screened. The selected articles were obtained and assessed for eligibility.

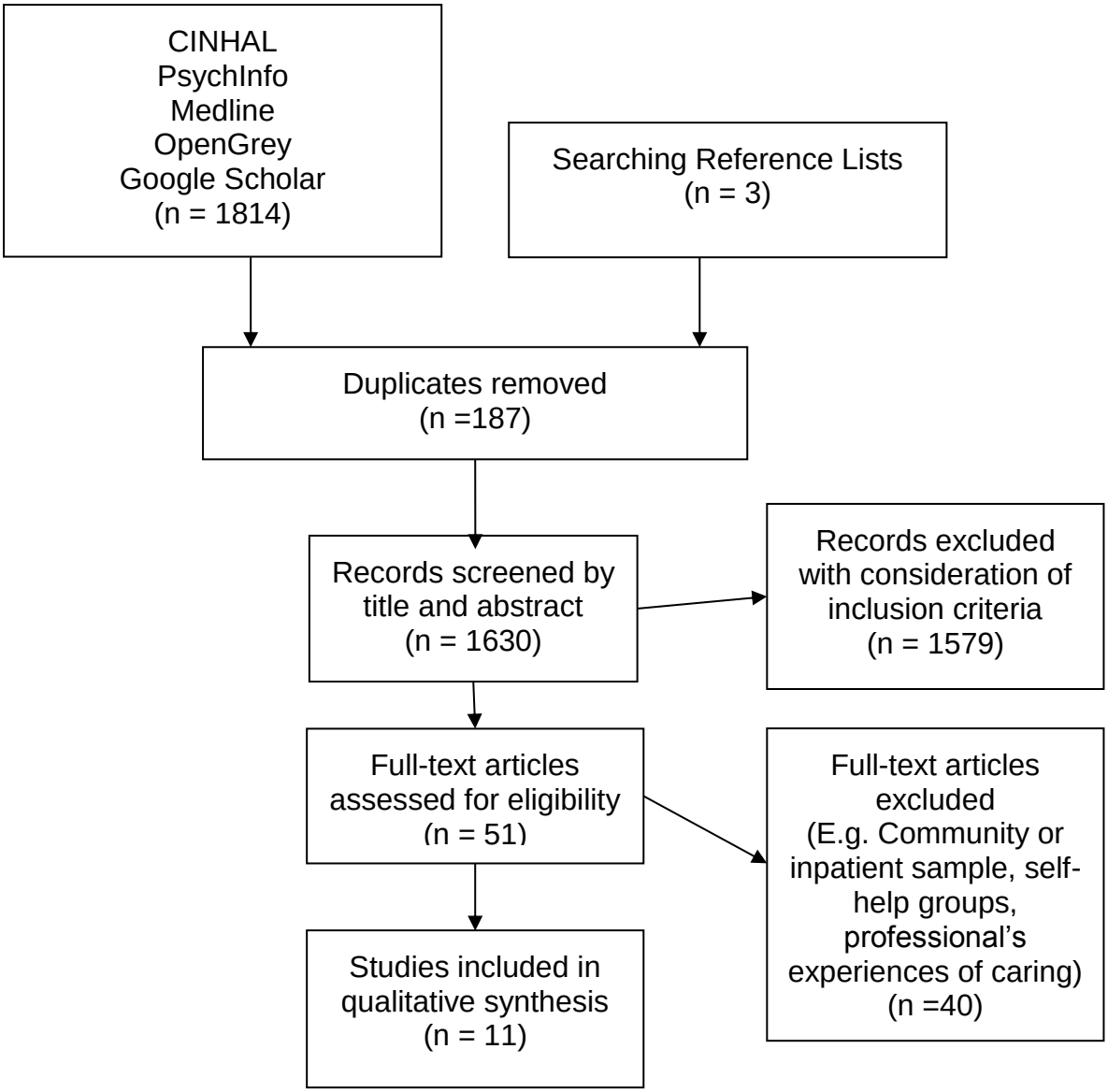
The above process produced 1817 articles which was reduced to 1630 when duplicates were removed. The 1630 articles were screened by title and/or abstract. This resulted in 51 full text articles being further assessed for eligibility.11 articles were deemed to meet inclusion criteria and were included in the final review. This process can be seen in Figure 1. Flow Diagram of studies

Data Extraction

Data was extracted from each qualitative and mixed methods article based on the data extraction form from Munro et al. (2007) and included: country, aims of study, ethics, study setting, sampling approach, participant characteristics, data collection methods, data analysis approach, key themes identified in the study, data extracts related to the key themes, and recommendations made by authors.

Data extraction from descriptive quantitative studies followed a similar approach with the inclusion of psychometric data and statistical analysis methods.

Fig. 1 Flow Diagram of Studies



Quality Assessment

For the qualitative articles the Critical Appraisal Programme Tool (CASP) Qualitative Checklist was used (CASP, 2010; Appendix A). The CASP contains 13 questions with additional prompts to guide appraisal. Areas of quality that are reviewed include the appropriateness of the study design; the consideration of

ethical issues; the rigour of analysis; appropriateness of the recruitment strategy; whether there was a clear statement of findings; and the value of the research.

For the descriptive quantitative studies and mixed methods articles, the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018; Appendix B and Appendix C) was used for quality assessment. Some areas of quality that are reviewed include the sampling strategy and representativeness, non-response bias, integration of results and interpretation.

Articles were deemed to be ‘weak’, ‘acceptable’ or ‘strong’ in quality.

Synthesis of data

For the qualitative and mixed method articles, a thematic synthesis was used and was guided by its use in other qualitative reviews (Morton et al., 2010). A thematic synthesis can be used to develop further understanding of the original analysis by considering deviating and overlapping themes across a range of articles. The Results sections of the articles were used to form the synthesis. This was carried out by noting important topics covered in the study after reading and rereading it. Convergent topics were identified and clustered to form themes. Each theme was then given an appropriate title.

For the quantitative articles, a synthesis of the main findings were used to highlight the experiences of larger numbers of individuals who attend A & E following self-harm.

Results

Aims

A clear statement of the aims of the research was given in all 11 studies and each was exploratory in nature. Although not every study was solely examining the experience of care at A & E (Harris, 2000; Taylor, 2003; Palmer, Strevens & Blackwell, 2006), there was reference made to the emergency department in all included studies.

Country

The majority of studies took place in the UK (Harris, 2000; Horrocks et al., 2005, 2005; Owens et al, 2016; Taylor, 2003; Hunter et al., 2013; O' Connor, 2015; Walker, 2017, Haw et al., 2003; Palmer, Strevens & Blackwell, 2006), with one based in the USA (Cerel, Currier, & Conwell, 2006) and one conducted in Finland (Suominen, Isometsä, Henriksson, Ostamo, & Lönnqvist, 2004).

Samples

The studies were made up of 957 participants in total, with 98 of these coming from the qualitative studies. The reporting of demographics varied, with some giving more detailed descriptions (Cerel, Currier, & Conwell, 2006; Suominen, Isometsä, Henriksson, Ostamo, & Lönnqvist, 2004; Owens et al, 2016; Haw et al., 2003).

Purposive sampling was used in 6 studies (Taylor, 2003; Hunter et al., 2013; O' Connor, 2015; Walker, 2017, Harris, 2000; Horrocks et al.,, 2005). The sampling method was not stated in 3 studies (Cerel, Currier, & Conwell, 2006; Palmer, Strevens & Blackwell, 2006; Owens et al, 2016). Prospective sampling was used by Haw et al. (2003) and Suominen, Isometsä, Henriksson, Ostamo, & Lönnqvist (2004) stated that they used systematic sampling, from consecutive cases presenting to hospitals.

Data Collection

Two of the studies used a survey with open-ended questions (Cerel, Currier, & Conwell, 2006; Palmer, Strevens & Blackwell, 2006). Haw et al. (2003) and Suominen, Isometsä, Henriksson, Ostamo, & Lönnqvist (2004) used structured interviews, which included psychometric measures. Two studies utilised written content as their means of gathering data; Harris (2000) collected letters about the experience of care for self-harm, while Owens et al. (2016) examined contributions to an online discussion forum. The remaining 5 studies used the interview method, with one study using a non-directive approach based on a free association narrative interview method (Horrocks et al., 2005), and the remaining four studies used semi-structured interviews (Taylor, 2003; Hunter et al., 2013; O' Connor, 2015; Walker, 2017). These were audio-recorded and transcribed. Hunter et al. (2013), O' Connor (2015), and Walker (2017) included topic guides and interview schedules.

Ethical Consideration

Five of the studies refer to ethical considerations (Owens et al., 2016; Hunter et al., 2013; O' Connor, 2015; Walker, 2017; Cerel, Currier, & Conwell, 2006). There was a combination of ethical approval granted from University review boards and NHS trust committees. None of the studies mentioned dissemination of results with those who participated. Table 1 is an overview of the 11 included studies and Appendices i, ii and iii display the quality appraisal.

Table 1. Overview of included studies

Study	Country	Sample	Aims	Data Collection	Data Analysis	Key Findings	Quality
Cerel, Currier, & Conwell (2006)	USA	355 patients and 188 family members	To understand the separate experiences of patients and family members in the ED following a suicide attempt.	survey with open ended questions	Thematic analysis and descriptive statistics	>50% of participants felt that staff treated them with respect and addressed ethnic and cultural issues appropriately. <40% of participants felt that staff listened, described the nature of treatments, or took their injury seriously.	Acceptable
Harris (2000)	UK	6 females, aged 20-45	What types of experiences have led women to engage in self-harm? How can we make sense of self-harm as a reaction to intense emotional stress?	letters to author	Not stated	Significant life events and hostile care in A & E departments	Acceptable
Haw, Hawton, Whitehead, Houston & Townsend (2003)	UK	135. 79 Female. Mean age 28.	patients' evaluation of DSH services, and the patients' outcome and satisfaction with the treatment they were offered	structured interviews	Fisher's exact test, independent-samples t-test, Mann-Whitney test, and $\chi 2$ test, with Yates' correction	80% reported understanding. Problems taken seriously for 86%. Not taken their problems seriously for 9%	Strong
Horrocks, Hughes, Martin, House & Owens (2005)	UK	27 female, 18 male, 18-56 years	Describe experiences of people attending hospital after self-harm and suggest ways to improve hospital care	Interviews used a non-directive approach based on a free association narrative interview method	Thematic analysis	Long waiting times and medical priority. Lack of privacy. Isolation. Feeling invisible. Poor Communication. Feeling of Being processed. Lack of empathy, acceptance and understanding.	Strong

Study	Country	Sample	Aims	Data Collection	Data Analysis	Key Findings	Quality
Hunter, Chantler, Kapur, & Cooper (2013)	UK	13. 7M. 20-60's.	explore service user experiences of assessment, and examine the short-term and longer-term meanings of assessment for service users	semi structured interviews	IPA	Function of psychosocial assessment unclear. Assessment as routine aspect of hospital care that can legitimise distress. Having someone to talk to alleviates distress and loneliness and aids recovery of self-worth.	Strong
O' Connor (2015)	UK	6 females 18-29, mean 23 years	exploring experiences of people who re-attend A & E with self-harm	semi structured interviews	IPA	Unresponsive care. Invalidation of distress. Abandonment on discharge	Strong
Owens, Hansford, Sharkey, & Ford (2016)	UK	31. 30 females. Mean age 19.5	To examine young people's perceptions of A & E treatment following self-harm and their views on what constitutes a positive clinical encounter	Secondary analysis of qualitative data from an experimental online discussion forum.	Thematic analysis	Participants reported avoiding A & E whenever possible, based on their own and others' previous poor experiences. When forced to seek care, they did so with feelings of shame and unworthiness. These feelings were reinforced when they received what they perceived as punitive treatment from A & E staff, perpetuating a cycle of shame, avoidance and further self-harm. Positive encounters were those in which they received 'treatment as usual'	Strong

Study	Country	Sample	Aims	Data Collection	Data Analysis	Key Findings	Quality	
Palmer, Strevens, & Blackwell (2006)	UK	206 adult service users	Understand needs and improve services for those who self-harm	Survey with open ended questions	Thematic analysis and descriptive statistics	Judgmental attitudes, lack of privacy, lack of information and communication, regular updates needed, more information about treatment and physical status needed, punitive/discriminating behaviour by staff	Acceptable	A
Suominen, Isometsä, Henriksson, Ostamo, & Lönnqvist (2004)	Finland	53 (30 females) Mean age 36.4 years	examine the patients' view of their psychiatric consultation after a suicide attempt.	structured interview with 11 items, likert scales. Suicidal Intention Scale (SIS), Hopelessness Scale (HS) and the BDI	Descriptive statistics	Hopelessness and depression were the strongest predictors of an indifferent attitude toward consultation. Self-poisoning attempters reported that the consultation came too early	Strong	
Taylor (2003)	UK	5 males. 18-40 years	identify what professionals, service providers and commissioners can learn from men who self-harm and propose ways forward to better meet their needs.	semi-structured interviews	Not stated	Influence of others' encounters at A & E. feel like a time waster. Poor physical care.	Weak	
Walker (2017)	UK	10 (5 females) 20's to 40's	How do people who have self-harmed, experience contact With mental health services in a general hospital?	semi-structured interviews	IPA	Negative staff attitudes. Traumatising environment. Lack of patient power	Strong	

Data Analysis

Interpretative Phenomenological Analysis was used to analyse the data in three of the studies (Hunter et al., 2013; O' Connor, 2015; Walker 2017). These were the only three papers to reflect on the possible impact of the relationship between the authors and participants. Thematic analysis was the method used by Owens et al. (2016) and Cerel, Currier, & Conwell, (2006). While Harris (2000), Horrocks et al. (2005) and Taylor (2003) did not state their method of analysis explicitly, it appeared to be based on thematic analysis. Suominen et al. (2004) created two linear regression models which looked at attitudes towards the psychiatric consultation. Fisher's exact test, independent- samples t-test, the Mann-Whitney test, and the $\chi 2$ test, with Yates correction were used by Haw et al. (2003).

Synthesis of Findings

The review found that client's experiences of care at A & E following self-harm varied greatly; however, there was more reporting of negative experiences. These were encompassed by negative staff attitudes, an unsuitable physical environment, and an internal experience of negative emotions. There was also reporting of what individuals found helpful during their visit to the emergency department. Appendix D shows which themes were present in each study and Appendix E demonstrates the themes and example data.

Negative Staff Attitudes

Judgement

Many individuals reported interactions with staff that were marred by a judgemental attitude (Palmer et al., 2007; Hunter et al., 2013; Horrocks et al., 2005; Harris, 2000; Cerel, Currier,& Conwell, 2006; Owens et al., 2016; Walker, 2017; Suominen et al., 2004). With these judgements came a lack of validation for the emotional distress they were presenting with. Participants felt that their personal histories could be held against them: 'they judge you if you're an addict, it's on your notes, you get terribly judged' (Hunter et al., 2013 p.319). This often created tension with staff and impacted negatively on future help-seeking behaviour. In an effort to avoid judgments and the associated shame, individuals often lie about the cause of their injury. Individuals were less likely to open up and be truthful with staff about their self-injury (Owens et al., 2016; Horrocks et al., 2005). This was more so the case with individuals who attend A & E repeatedly due to self-harm:

'Because I have been seen at this A & E on a number of occasions I feel very judged by the staff and they have a negative attitude towards me. It's as if they are thinking 'not her again'.' (Palmer et al. 2007, p.14)

Other participants also believed that some of the judgemental and negative attitudes they perceived were specifically due to their presentation with self-harm. Client's sense of loneliness and worthlessness can be reinforced by the perception that they were being judged:

'they wouldn't touch me…they looked at me as if to say 'I'm not touching you in case you flip'..they didn't actually say it but it was their attitude…but there again I can understand nurses being a bit scared.' (Horrocks et al., 2005, p.12)

These judgements can be seen as a product of societal stigma with regard to mental health, and self-harm, in particular. However, this stigma can be internalized and often leads to the experience of negative emotions (Walker, 2017). These negative emotional states will be further discussed in detail.

Unpredictability

Individual's encounters with staff were characterised as inconsistent by many (O Connor, 2015; Hunter et al., 2013). This led to increased anxiety and uncertainty as to what to expect from the caring relationship:

'Sometimes the staff are like really, really nice to you and really reassuring and then other times they'll be really, sort of belittle you…they can be a bit like horrible' (O' Connor, 2015, p.57)

This inconsistency can also be seen in relation to discharge and follow-up. When the care that is needed is unreliable and ambiguous in its delivery, client's often end up feeling frustrated and helpless. Many individuals were unsure of the next steps after their presentation to hospital and expected that some further arrangements would be organised (Hunter et al., 2013).

Staff not engaged

Many more clients experienced staff at the A & E to be 'not fully engaged' in working with them (Hunter et al., 2013..Horrocks et al., 2005) and thought that they were carrying out the assessments purely as a protective measure for the hospital: 'It's one of those things isn't it, he's got to ask it, just to cover himself' (Hunter et al., 2013, p.318)

This conjured up images of being processed for some participants and this was heightened by the use of perceived 'stock' questions with little concern for rapport in the relationship (Horrocks et al., 2005). Individuals reported wanting to be

involved in care decisions and to be informed of the steps to be taken in their hospital visit, but this was often lacking (Horrocks et al., 2005; Hunter et al., 2013; Owens et al., 2016). They described poor communication where the results of blood tests and other physical examinations were not shared with them.

‘Some doctors seem to think there is a relationship between self-harm and not being able to hear, so they don’t bother addressing you but just talk to anyone who happens to be with you’ (Owens et al., 2016 et al., p.288)

Others felt that staff weren’t engaged due to poor knowledge around self-harm and an uncertainty of how to manage it (O’ Connor, 2015). This hesitancy was sometimes interpreted as staff trivialising the behaviour and not seeing it as a means of coping with emotional distress:

‘You treat me like I’ve just walked in from a flat up the road and this is like a hobby for me; it’s not’ (O’ Connor, 2015 p.60).

An Unsuitable Physical Environment

Physical Health versus Mental Health

When it came to being attended to at A & E, participants reported feeling different from others who were there for physical health reasons (O’ Connor, 2015; Cerel, Currier,& Conwell, 2006; Owens et al., 2016). This tended to compound feelings of worthlessness, guilt, and shame related to help-seeking for self-inflicted injuries:

‘Cause if like someone came in with a broken leg and they were absolutely balling their eyes out, they’d sit and talk to them, and they’d calm them down, but they wouldn’t do that for mental health patients I don’t think’ (O’ Connor, 2015, p.65)

Individuals wanted equality in their treatment alongside those presenting with physical health issues, but also highlighted divergent needs. One participant likened

their help-seeking to individuals who repeatedly present to hospital for injuries sustained through risky sports and can do so without being 'punished' by staff (Owens et al., 2016).

Logistics of the Environment

As well as feeling different from the physical health patients, individuals noted issues with the environment that impacted on their visit to A & E (O' Connor, 2015; Horrocks et al., 2005; Walker, 2017; Palmer et al., 2007; Cerel, Currier,& Conwell, 2006; Suominen et al., 2004). Participants spoke about the sensitive nature of their reasons for seeking help and how a lack of privacy was not afforded to them when discussing their injury. This heightened anxiety and self-consciousness and made it difficult for them to engage in an already testing assessment:

'When they come in here it should be in a private room, I don't want everyone knowing my woes and troubles' (Walker, 2017, p.114)

This was often after waiting for long periods of time (O' Connor, 2015; Horrocks et al., 2005; Cerel, Currier, & Conwell, 2006), where they felt that physical health patients were seen as a priority. While waiting to be seen, many individuals reported feelings of isolation which further escalated their emotional distress (Horrocks et al., 2005; Cerel, Currier, & Conwell, 2006). This often resulted in urges to leave the hospital after, perhaps, being forced to attend by a friend or family member in the first place (O' Connor, 2015).

The reputation of the A & E experience sometimes preceded an actual visit and set certain expectations for individuals (Taylor, 2003; Horrocks et al., 2005; Owens et al., 2016).

'I've heard some really horrible stories about A & E' (Taylor, 2003, p.88).

Inner Turmoil / Experience

Negative Emotions

Many of the participants across the studies spoke about or highlighted in surveys the experience of significant negative emotions while attending A & E following self-harm (O' Connor, 2015; Owens et al., 2016 et al.; Cerel, Currier,& Conwell, 2006; Taylor, 2003 ; Horrocks et al., 2005; Walker, 2017; Haw et al., 2003). While they generally presented in states of distress, this was compounded by their interactions with staff. Individuals were left with feelings of powerlessness and helplessness (Owens et al., 2016; O' Connor, 2015) when they voiced concerns and tried to illicit more care:

'I've learnt to keep my mouth shut because I can say too much' (O' Connor, 2015, p.59)

Participants described how they thought of themselves as 'time wasters' or how they got the impression that staff believed that to be the case (Taylor, 2003; Horrocks et al., 2005; O' Connor, 2015). Some individuals thought that they were 'taking time away from real patients' (Cerel, Currier, & Conwell, 2006) in the setting catering predominantly for patients with physical complaints.

This fostered a perceived sense of abandonment on discharge and they were left hopeless about future help-seeking (Horrocks et al., 2005; O' Connor, 2015). Individuals sought more care for the physical effects of self-harm in these moments, while also wanting to understand what led them to this crisis point:

'I was going back to where I started, I felt confused, I thought 'what were the point of coming to hospital?'' (Horrocks et al., 2005, p. 13)

This began the cycle of shame and worthlessness again, which accompanied them to subsequent presentations to A & E and complicated the already complex

process of help-seeking for self-injurious behaviour (Owens et al., 2016 et al.: Walker, 2017).

What is perceived as helpful?

Regular check-ins

Participants appreciated when staff took a small amount of time to check in on them and kept them informed of wait times and what to next to expect (Horrocks et al., 2005; Palmer et al., 2007; O' Connor, 2015). This generally led to better engagement with the service. A concrete expression of care such as offering them a glass of water often sufficed.

'It makes me want to stay and wait, and it makes me want to feel better' (Palmer et al., 2007, p.17)

Making sense of the reasons behind the act of self-harm and discussing these further with staff was significantly important for participants as it helped combat the struggle with worthlessness (Hunter et al., 2013).

Distress Recognised

With regular check-ins comes the recognition of the individual's distress and that their concerns are genuine and deserving of psychiatric care (Hunter et al., 2013; Owens et al., 2016; Haw et al., 2003). This included some informal chat about 'random stuff' along with questions geared towards assessment, without 'asking the same old psych questions 100 times' (Owens et al., 2016, p.288).

While feelings of shame often shadowed their experience of help-seeking, having a clinician legitimise their distress allowed them to recover a sense of self-worth. One participant spoke about the value of someone understanding her pain and how 'relieved' she was to be taken seriously (Hunter et al., 2013). These types of

interactions encouraged hope for the future when staff were deemed to be non-judgemental and empathetic:

‘I think I’ve got more confidence to get in touch with somebody now, before trying to do something like that’ (Hunter et al., 2013, p. 320)

Haw et al. (2003) reported that 80% of their 90 participants described their assessor as understanding and that 86% had their problems taken seriously.

Discussion

This systematic review of the literature about the perception of the A & E experience by adults following an act of self-harm has demonstrated that regardless of the different national health policies and procedures that are put in place, there is an overwhelmingly negative perception of the care received. Individual's had concerns regarding negative staff attitudes that were characterised by judgement, unpredictability, and staff who were not engaged; the unsuitable physical environment; and widespread negative emotions that were compounded by their visit to the A & E. Positive encounters at the emergency department were associated with regular check-ins by staff during often long wait times, and a recognition of their distress as legitimate, which was conveyed by empathic care and non-judgemental attitudes.

Across studies participants made suggestions for the improvement of the A & E experience following an act of self-harm. This involved inclusion of individuals in their care plans with more transparency regarding next steps in treatment, clearer communication about follow up services, and a different style of staff engagement.

This study adds to the ever growing literature on self-harm. It highlights the marked variation in the type and quality of services available to people presenting to A & E after a self-harm episode (Bennewith et al., 2004) and reinforces the idea that the therapeutic relationship is an important tool in improving treatment adherence and client outcomes (Haw et al., 2003).

Limitations and Strengths

Findings from the synthesis need to be interpreted with consideration of possible limitations. In the process of searching for the literature it was deemed appropriate to use the psychological term 'clients' instead of 'patients'. On further reflection this may have somewhat limited the results, although it still produced articles which used the medical term. The finalised studies from the search utilised several different methodologies which makes the process of comparison difficult to a certain extent. Various international healthcare systems, including the UK, USA, and Finland, also impacts on comparability. Most of the qualitative research used semi-structured interviews which means the exact number of participants who held certain attitudes could not be ascertained due to the likelihood that questions reminded participants of slightly different experiences. Publication bias has to be considered as there is a

higher chance of negative findings being highlighted. The search for grey literature was hoped to counteract this aspect. There is also a chance of bias by the review researcher. By collating already synthesised results, the related interests of the reviewer may impact on findings. While the use of thematic synthesis was helpful in categorizing themes, the usefulness of the review could be expanded if the findings were gathered and coded by several researchers. One also has to consider the quality of the included studies in the final write up. However, notwithstanding the greater emphasis given to the studies with better designs, it is still possible that the reporting of all findings could have impacted on overall conclusions. Thought also has to be given to the fact that up to 15% of people who present to A & E following self-harm will leave before it is recommended (Griffen et al., 2018). This significant proportion of individuals may have particular insights about the A & E experience that could be valuable, as something about their time there led them to reject the care offered to them.

A strength of this review is the specificity to the experience of adult's help-seeking at A & E. With the emergency department seen as an important entry point for engagement with services (Royal College of Psychiatrists, 2010), it is important to understand what can be improved at this point to ensure uptake with community services and to limit future risk.

Clinical Implications

Exploring the views of those who attend A & E following self-harm is central as a preventative measure for future harm. The findings from this review suggest that there are environmental aspects of the hospital along with staff attitudes that impact on service user experience. There are also emotional states of fear and vulnerability that create difficulties for individuals where underlying trauma is common (Glassman, Weierich, Hooley, Deliberto, & Nock, 2007). A trauma informed approach to the A & E experience may be one solution to address all three areas. As services stand, they can retraumatise service users through overarching themes of authority and enforcement (Bloom and Farragher, 2010). This needs to be understood within all aspects of the service, including reception and waiting rooms (Lambert, Horan, Naughton, & Gill-Emerson, 2017).

Trauma informed services are developed in such a way as to create a sense of safety and trust without retraumatising. The Substance Abuse and Mental Health Services Administration (SAMHSA; 2014) is one model of trauma informed care that

follows principles of safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural competence. Essentially, this accounts for a change in thinking from ‘what is wrong with you?’ to ‘what happened to you?’ This falls in line with findings from the review in that participants wanted more than just physical care and needed to discuss the background to their self-harm. They needed to be ‘seen and heard’ in the busy environment of the A & E. A full overhaul of services may not be feasible, but staff training on understanding trauma informed care may be a solution.

Future Research

The current research has examined the experience of traditional A & E services. If trauma informed services were to be developed it would be beneficial to research the effects on Service User satisfaction with the care received; levels of re-attendance for self-harm; levels of uptake for community follow-up services; overall levels of self-harm in an area as measured by the National Suicide Research Foundation; staff satisfaction with the delivery system; staff stress/burnout levels with the new system; economic impact of trauma informed service.

A possible control study could be to look at perceptions of care for physical health needs alone and to examine the findings from it in light of what has already been found in relation to care for self-harm.

Conclusion

This review offers some insight into how the A & E experience can be improved for those who present with self-harm. Although current positive characteristics should be preserved, it is evident that Service Users are dissatisfied with certain aspects of the physical environment and some staff attitudes. However, more research is necessary to explore alternative delivery systems and to assess feasibility.

References

Babiker, G. & Arnold, L. (1997). The Language of Injury: Comprehending Selfmutilation. Leicester: British Psychological Society.

Bergen, H., Hawton, K., Waters, K., Cooper, J., Kapur, N. (2010). Epidemiology and trends in non-fatal self-harm in three centres in England: 2000-2007. British Journal of Psychiatry, 197, 493-498.

Cerel, J., Currier, G. W., & Conwell, Y. (2006). Consumer and Family Experiences in the Emergency Department Following a Suicide Attempt. Journal of Psychiatric Practice, 12(6), 341–347. doi:10.1097/00131746-200611000-00002

Chapman, A. L., Gratz, K. L., Brown, M. Z. (2006). Solving the puzzle of deliberate selfharm: the experiential avoidance model. Behaviour Research and Therapy, 44, 371–394.

Chapman, R. & Martin, C. (2014). Perceptions of Australian emergency staff towards patients presenting with deliberate self-poisoning: a qualitative perspective. Int Emerg Nurs; 22: 140–5.

Cooper, J., Kapur, N., Webb, R., et al (2005). Suicide after deliberate self-harm; a 4-year cohort study. American Journal of Psychiatry, 162, 297–303.

Corcoran, A. (2006). Adverse Childhood Experiences and Lifetime Suicide Ideation: A Cross-Sectional Study in a Non-Psychiatric Hospital Setting Ir. Med. J., 99, 42–45.

Corcoran, J., Mewse, A. & Babiker, G. (2007). The role of women's self-injury support-groups: a grounded theory. Journal of Community & Applied Social Psychology; 17:35–52.

Critical Appraisal Skills Programme (2018). CASP Qualitative Checklist.

Felitti V. J., Anda R. F., Nordenberg D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). The relationship of adult health status to childhood abuse & household dysfunction. American Journal of Preventive Medicine, 14, 245–258

Ford, J. (2018). Complex Trauma and Developmental Trauma Disorder in Adolescence. *Adolescent Psychiatry*, *7*(4), 220-235.

Fortune, S., Sinclair, J. & Hawton, K. (2008). Adolescents' views on preventing selfharm. Social Psychiatry and Psychiatric Epidemiology, 43, 96–104.

Glassman, L. H., Weierich, M. R., Hooley, J. M., et al. (2007). Child maltreatment, non-suicidal selfinjury, and the mediating role of self-criticism. Behaviour Research and Therapy, 45, 2483–2490.

Griffin, E, Dillon, CB, McTernan, N, Arensman, E, Williamson, E, Perry, IJ, Corcoran, P, (2018). National Self-Harm Registry Ireland Annual Report 2017. Cork: National Suicide Research Foundation.

Griffin, E., Dillon, C., O'Regan, G., Corcoran, P., Perry, I., & Arensman, E. (2017). The paradox of public holidays: Hospital-treated self-harm and associated factors. *Journal Of Affective Disorders*, *218*, 30-34.

Guthrie, E., Kapur, N., Kway-Jones, K., et al. (2001). Randomised controlled trial of brief psychological intervention after deliberate self poisoning. British Medical Journal, 323, 135–138.

Harris, J. (2000). Self harm: cutting the bad out of me, 10(2), 164–173. Retrieved from http://eprints.whiterose.ac.uk/55746/

Haw, C. & Hawton, K. (2008). Life problems and deliberate self-harm: associations with gender, age, suicidal intent, psychiatric and personality disorder. Journal of Affective Disorders, 109, 139–148.

Haw, C., Hawton, K., Houston, K., et al. (2001). Psychiatric and personality disorders in deliberate self-harm patients. British Journal of Psychiatry, 178, 48–54.

Haw, C., Hawton, K., Whitehead, L., Houston, K., & Townsend, E. (2003). Assessment and aftercare for deliberate self-harm patients provided by a general hospital psychiatric service. Crisis, 24(4), 145–150.

Hawton, K. & Fagg, J. (1988). Suicide and other causes of death following attempted suicide. British Journal of Psychiatry, 152, 359–366.

Hawton, K., Rodham, K., Evans, E., et al. (2002). Deliberate self-harm in adolescents: self report survey in schools in England. British Medical Journal, 325, 1207–1211.

Horrocks, J., Hughes, J., Martin, C., House, A., & Owens, D. (2005). Patient experiences of hospital care following self-harm - A qualitative study. Leeds: University of Leeds.

https://ec.europa.eu/eurostat/web/products-eurostat-news/-/DDN-20170517-1

Hunter, C., Chantler, K., Kapur, N., & Cooper, J. (2013). Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking: A qualitative study. Journal of Affective Disorders, 145(3), 315–323.

Karman, P., Kool N., Poslawsky, I.E., & Van Meijerl, B. (2015). Nurses' attitudes towards self-harm: a literature review. Journal of Psychiatric and Mental Health Nursing, 22, 65-75.

Kendall, T. (2004). "Clinical Guidelines in Mental Health I: The National Collaborating Centre for Mental Health". BJPsych Bulletin. 28 (5).

Lambert, S., & Gill-Emerson, G. (2017). Moving towards trauma-informed care. A model of research and practice. Retrieved from http://www.drugsandalcohol.ie/28377/1/Moving-Towards-TraumaInformed-Care-Report.pdf

Lynch, O. & Lambert, S. (2016). EU Issue Paper on Child Returnees to Europe from ISIL held territories in Syria/Iraq. https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-wedo/networks/radicalisation_awareness_network/ranpapers/docs/issue_paper_child_returnees_from_conflict_zones_112016_en.pdf

McHale, J., & Felton, A. (2010). Self-harm: what's the problem? A literature review of the factors affecting attitudes towards self-harm. Journal of psychiatric and mental health nursing, 17(8), 732- 740.

Middleton, N., Whitley, E., Frankel, S., Dorling, D., Sterne, J. & Gunnell, D. (2004). Suicide risk in small areas in England and Wales, 1991–1993. Soc Psych Psychiatr Epidemiol 39:45–52.

Middleton, N., Whitley, E., Frankel, S., Dorling, D., Sterne, J. & Gunnell D. (2004). Suicide risk in small areas in England and Wales, 1991–1993. Soc Psychiatry Psychiatr Epidemiol; 39:45–52.

Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., Shekelle, P. & Stewart, L.A. (2015). Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) 2015 statement. Syst Rev.;4(1):1.

Munro, S., Lewin, S., Swart, T., & Vomink, J. (2007). A review of health behavior theories: How useful are these for developing interventions to promote longterm medication adherence for TB and HIV/AIDS? BioMed Central Public Health, 7, 104–120.

Murray, C.J., Vos, T., Lozano, R., et al. (2012). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2012: a systematic analysis for the Global Burden of disease Study 2010. Lancet; 380:2197–223.

College of Psychiatrists of Ireland. (2016) National Clinical Programme For the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm. Dublin. College of Psychiatrists of Ireland.

Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A., et al. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. Br J Psychiatry, 192(2), 98-105.

O' Connor, S. (2015). Experiences of the relationship between hospital staff and people who self-harm by. Unpublished

O'Connor, R. C., Rasmussen, S. & Hawton, K. (2009a). Predicting deliberate self-harm in adolescents: a six month prospective study. Suicide and Life-Threatening Behavior, 39, 364–375.

Owens, C., Hansford, L., Sharkey, S. and Ford, T. (2016). Needs and fears of young people presenting at accident and emergency department following an act of

self-harm: secondary analysis of qualitative data. *British Journal of Psychiatry*, 208(03), pp.286-291.

Palmer, L., Strevens, P., & Blackwell, H. (2006). Better Services for People who Selfharm: Data Summary - Wave 1 Baseline Data. London, Royal College of Psychiatrists.

Pembroke, L. R. (1994). Self-harm: Perspectives from Personal Experience. London: Survivors Speak Out.

Perry, I.J., Corcoran, P., Fitzgerald, A.P., Keeley, H.S., Reulbach, U. & Arensman, E. (2012). The incidence and repetition of hospital-treated deliberate self harm: findings from the world's first national registry. PLoS ONE, 7(2):e31663.

Rees, N., Rapport, F., Thomas, G., John, A. & Snooks, H. (2014). Perceptions of Paramedic and Emergency Care Workers of those who Self Harm: A Systematic Review of the Quantitative Literature. Journal of Psychosomatic Research. 77 449–456.

Royal College of Psychiatrists. (2010). Self-harm, Suicide and Risk: Helping People who Self-harm (Council Report 158). London: Royal College of Psychiatrists.

Sinclair, J., Gray, A. & Hawton, K. (2006). Systematic review of resource utilization in the hospital management of deliberate self-harm. Psychological Medicine 36: 1681–1693.

Spinazzola, J., van der Kolk, B., & Ford, J. (2018). When Nowhere Is Safe: Interpersonal Trauma and Attachment Adversity as Antecedents of Posttraumatic Stress Disorder and Developmental Trauma Disorder. *Journal Of Traumatic Stress*, *31*(5), 631-642.

Substance Abuse and Mental Health Services Administration (SAMHSA). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: substance Abuse and Mental health Services Administration, 2014. http://store.samhsa.gov

Suominen, K., Isometsä, E., Henriksson, M., Ostamo, A., & Lönnqvist, J. (2004). Patients' evaluation of their psychiatric consultation after attempted suicide. Nordic Journal of Psychiatry, 58(1), 55–59.

Swales, M. (2005). Pain and deliberate self-harm. The Wellcome Trust (http://www.wellcome.ac.uk/en/pain/microsite/culture4.html).

Taylor, B. (2003). Exploring the perspectives of men who self-harm. Learning in Health and Social Care, 2(2), 83–91.

Walker, S.C. (2017). How do people who have self-harmed, experience contact with mental health services in a general hospital?: An exploratory study using interpretative phenomenological analysis. Unpublished.

Yates, T.M., Carlson, A.E.A., & Egeland, B. (2008). A prospective study of child maltreatment and self-injurious behavior in a community sample. Development and Psychopathology, 20, 651–671.

Reasons why men who present with self-harm leave Accident and Emergency before next care recommendations; An Interpretive Phenomenological Analysis (IPA)

Donal Moynihan[1], Dr Sharon Lambert[2], Daniel Flynn[3], and Dr James Kinahan[4]

[1,2]School of Applied Psychology, University College Cork

[3,4]Health Service Executive

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Abstract

There is a significant proportion of people who attend A & E with self-harm and leave before receiving appropriate psychosocial assessment and do not get next care recommendations. Males aged between 25 and 44 years are at the greatest risk of leaving without appropriate care. The aim of the current study is to explore the factors that impact males who leave. It is hoped that insights into this process may offer potential opportunities for A & E staff to engage differently with this client population. Data from six semi-structured interviews were analysed using Interpretive Phenomenological Analysis. Five superordinate level themes emerged from the data: *Safety and other Service Users; Waiting in the shadows; A compounding of distress; Expectations from experience; and Client-clinician relationships.* To the authors' knowledge this is the first study exploring the reasons for such self-discharge. Despite individualised differences, one would hope that the care can be improved through training and education for staff to ensure a more positive experience resulting in fewer men leaving.

Key words: Self-harm; accident and emergency (A & E); IPA; early discharge

Introduction

Self-harm is a major worldwide concern (Murray et al., 2010) and Ireland is included in this epidemic (Perry et al., 2012; Griffin et al., 2017). Research has demonstrated that 20-25% of individuals who die by suicide have engaged in an act of self-harm within the 12 months before their death (Hawton, 1998; Bergen et al., 2010). This is concerning because of both the cost in terms of health service utilisation and personal cost due to the increased risk of suicide (Owens, Horrocks, & House, 2002; Sinclair, Gray, & Hawton, 2006).

Interpersonal difficulties are often cited as interconnected to self-harm (Haw and Hawton, 2008; Middleton et al., 2004). Research has demonstrated that up to 50% of presentations for self-harm to Accident and Emergency (A & E) involve individuals with a personality disorder diagnosis (Haw et al., 2001). However, these diagnostic criteria may exacerbate stigma and hinder appropriate help-seeking (Fortune et al., 2008). Some propose a reclassification of personality disorders as responses to complex developmental trauma (Spinazzola, van der Kolk & Ford, 2018; Ford, 2018). Among many reasons, it is thought that this reclassification may help with the stigma surrounding the disorders and aid in the delivery of care.

A & E is more and more identified as a significant location for the introduction of suicide and self-harm prevention measures (Boudreaux et al., 2013). In Ireland in 2016, the National Self-Harm Registry logged 11,485 presentations to hospital due to self-harm. The male rate was 206 per 100,000, which is 10% higher than when economic recession hit in 2007. Cork city had the highest rate for males, which was 2.2 times higher than the national average (Griffin et al., 2018).

Males tend to use methods with higher lethality, which is reflected in the fact that attempted hanging was involved in just over 1 in 10 of self-harm presentations (Arensman, et al., 2013). Cutting was also more common in men and alcohol was significantly more often involved in male presentations, which is a worrying trend (Griffin et al., 2018). A dependence on, and/or misuse of alcohol is positively correlated with suicidal behaviour (Murphy, 2000). Those with hazardous use of alcohol are at nearly six times the lifetime risk of dying by suicide compared to those who don't (Harris and Barraclough, 1997).

Guidance from clinicians (Isacsson and Rich, 2001) and clinical guidelines (Royal College of Psychiatrists, 2004) recommend that psychosocial assessment in A & E is a central component in the management and prevention of self-harm. This includes an assessment of mental state, risk, needs, and social and personal background. The assessments are deemed to be of benefit on both a practical and therapeutic level. It may increase the likelihood of attending follow-up care (Kapur et al., 1998; Barr, Leitner & Thomas, 2005) and the assessment itself at time of presentation to the ED can be therapeutic for some (Whitehead, 2002). Nevertheless, there are differences in the rates of assessments being carried out between hospitals in both Ireland and England (Bennewith et al., 2004; Griffin et al., 2018). In 2017, 72% of Irish patients received a psychosocial assessment after presenting to hospital (Griffin et al., 2018).

Successful care of self-harm and suicidal behaviours offers an inroad for managing underlying psychological distress and may make an important contribution to suicide prevention (Department of Health, 2002). Leaving before agreeing upon the next care session limits the potential to engage in an effective intervention to address the root causes of the self-harm (Slee, Garnefski, van der Leeden et al.,

2008). It has also been noted in previous research that engagement with follow up services acts as a preventative measure for further suicidal behaviours (Appleby, Shaw, Amos et al., 1999).

Those who self-harm are a vulnerable client group who remain hidden for the most part and an A & E presentation can be seen as a significant occasion for engagement and deploying suicide preventative measures (Hawton et al., 2002). However, despite national guidelines (College of Psychiatrists of Ireland, 2016) for the delivery of care to those who self-harm, challenges remain in optimising engagement with these vulnerable patients. Clinical interactions have been marred by instances of perceived disrespect and misunderstanding which sometimes occur due to poor communication and lack of involvement in care (Owens et al., 2016; Hunter et al., 2013). This can serve to reinforce experiences of shame and isolation and further comprimise efforts at seeking help after episodes of emotional and behavioural dysregulation (Horrocks et al., 2005; Palmer et al., 2007).

The importance of a helpful interaction at A & E cannot be stressed enough, due to the heightened risk of suicide following self-harm (Bergen et al., 2010; Sinclair, Gray, & Hawton, 2006). Forging strong clinical alliances and encouraging empathy and collaboration with those presenting with self-harm is essential to ensure a reduction in levels of premature discharge from the A & E (Royal College of Psychiatrists, 2010; Hunter et al., 2013). There have been findings to suggest that staff have difficulty developing rapport at times due to underlying perceptions of those who self-harm. This can lead to detachment in the clinical relationship being used as a coping mechanism (Chapman & Martin, 2014). Staff have also reported experiences of frustration and powerlessness (Rees et al., 2014; Karman, Kool,

Poslawsky, & Meijel, 2015) which may foster a ‘client blameworthy perspective’ impacting on treatment (McHale & Fenton, 2010).

There is a significant proportion of those who attend the A & E with self-harm that leave before the appropriate psychosocial assessment can be carried out and do not get a next care recommendation (Kapur et al., 1998; Arensman et al., 2018). Hickey et al. (2001) reported that this sample of individuals are more likely to repeat an act of self-harm within 12 months and are also at a heightened risk of needing psychiatric interventions. Another study reported that they are estimated to be three times more likely to engage in a repeat act of self-harm (Crowder et al., 2004). Several studies have reported that psychosocial assessment may impact positively on attitudes to further help-seeking and thus reduce the impact of self-harm (Horrocks et al., 2005; Palmer, Strevens, & Blackwell, 2006). Failure to receive an assessment could be attributed to flaws in service design (Hughes et al., 1998), but it is also extremely important to try hear the voice of those who self-discharge prior to receipt of an appropriate follow-up care plan.

Kapur et al. (2008) found that particular subgroups are less likely to engage in the assessment process. These include the unemployed, those engaged in cutting, and the young, which is of particular concern as it is well documented that negative outcomes are associated with these groups of individuals. Of particular concern is the finding that they are at a heightened risk of dying by suicide (Zahl and Hawton, 2004; Cooper et al., 2005). Reasons cited for their disengagement include the time of presentation and not currently receiving psychiatric interventions. In another study, it was reported that self-poisoning, first reported incidence of self-harm, and no prior interaction with their local Community Mental Health Team was associated with premature self-discharge (Crowder et al., 2004). A recent large scale Irish study

(Arensman et al., 2018) reported that males aged between 25 and 44 years who presented after drug overdose or attempted drowning were at the greatest risk of leaving without appropriate care. They were inclined to attend A & E at night time, were more often city residents or people experiencing homelessness, and had previous episodes of self-harm. Males who leave before completing the psychosocial assessment are a group where there are gaps in our knowledge, and it warrants further research.

If staff better understood the reasons why males presenting with self-harm leave before next step care recommendations can be made, they could potentially provide more effective interventions in A & E. With consideration of the above, there is limited knowledge with regard to males who leave before a psychosocial assessment can be carried out following self-harm or suicidal behaviours and there are no qualitative findings exploring reasons for self-discharge. The aim of the current study is to use Interpretive Phenomenological Analysis to explore the lived experience of males who self-harm and leave the A & E before accessing a psychosocial assessment and receiving next care recommendations. It is also hoped to explore how insights into this process may offer potential opportunities for A & E staff to engage differently with this client population.

Method

Participants

Participants meeting inclusion criteria were identified by the Suicide Crisis Assessment Nurses and Consultant Psychiatrist (JK) in one of two urban teaching hospitals in the south of Ireland by purposive sampling between May 2018 and January 2019. As part of routine clinical practice, individuals who leave A & E before next care can be recommended receive a follow-up phone call. As part of this phone call, it was explained that there was research being carried out and individuals were asked for their consent to be contacted by the researcher. A letter of invitation (Appendix G), study information leaflet (Appendix H), and leaflet of supportive services (Appendix I) was then sent and this was followed up by a phone call in the following days. Those who wished to take part were scheduled in for an interview in the community psychology building. 12 people opted-in to take part; 4 did not respond to follow up contact, 1 person declined, and 1 person did not attend. In total, 6 Irish males aged 21 to 47 were interviewed after giving informed consent (Table 2.). Pseudonyms have been used throughout to protect the anonymity of the participants.

Table 2. Participant Demographics and Method of Self-Harm

Pseudonym	**Age**	**Type of self-harm at presentation to A&E**	**Previous self-harm**	**Living arrangements**
Michael	21	Cutting	Multiple episodes	Lives with mother
Luke	46	Jumping from height	Multiple episodes	Lives alone
Maurice	22	Cutting	Multiple episodes	Lives with mother
Niall	44	Cutting	Multiple episodes	Lives alone
Terry	43	Attempted drowning	Multiple episodes	Homeless
Eoin	47	Overdose	Infrequently	Lives alone

Inclusion and Exclusion Criteria

Eligible participants were males over 18 years of age who presented to A & E in the study hospitals following an act of self-harm and left before next care recommendations could be made. Service Users were excluded if they could not be contacted on discharge from A & E or if they did not give informed consent to the clinician to be further contacted by the researcher. There was a protocol in place to exclude participants if they were deemed to be significantly impacted by drugs or alcohol at the time of the interview, or if they presented as severely emotionally dysregulated, or appeared to be in a dissociative state or psychotic state. However this was not needed when the interviews were conducted.

Data Collection

Semi-structured interviews were carried out by DM with 6 participants in the weeks following their presentation to A & E (average time to interview was 3 weeks). It was deemed appropriate to cease data collection, in accordance with Turpin et al. (1997) recommendation of 6-8 participants. Smith, Flowers, & Larkin (2009) also reported that IPA is best carried out with a small homogenous sample. An interview schedule (Appendix J) was developed with the consultation of both the field and research supervisor, in line with IPA guidance on data collection (Smith, Flowers, & Larkin, 2009). This consisted of beginning the interview with open questions about the A & E presentation before moving on to more detailed aspects of the experience.

Interviews were on average 50 minutes, with a variation of 40 minutes to 75 minutes. They were audio-recorded on a Dictaphone and transcribed verbatim by the first author. The text files contained no identifying details. Participants were offered the opportunity to receive the final write-up when completed. Supervision was used

to discuss any observations, the process, and reactions after each interview, or to appropriately follow up on any immediate care needs for the participant if required.

Analysis

Interpretive Phenomenological Analysis (IPA; Smith & Osborn, 2008; Smith, Flowers, & Larkin, 2009) was used by the author to analyse the data. There is an emphasis on how individuals make meaning from their experience of a certain phenomenon. IPA recognises the impact of the researcher's orientation on the data collection process and final write-up, due to it being an interpretive and inductive method (Smith et al., 2009). This idiographic method leads to a co-constructing of meaning between researcher and participant. IPA is favourable over more socially constructed methods such as Discourse Analysis (Gee, 2005), as it stays closer to individual's lived experience of the particular phenomenon.

Conceptual, linguistic, and descriptive aspects of note were recorded in one margin and codes were developed in the other for each transcript. A line by line approach was utilised with multiple re-reads and referrals to the data to increase familiarisation (Smith & Osborn, 2003; Appendix xi Analysis). The themes were further examined to understand the connections between them, resulting in a set of superordinate themes for the transcript. Notes were made for where supporting extracts could be found within the data.

This procedure was replicated for each transcript with the eventual establishment of superordinate and subthemes across the 6 interviews. Throughout this process there was constant referral to the original transcript to ensure the analysis was grounded in the data. Another researcher reviewed the themes for reliability and appropriate representation in the data. A narrative account was then

created to explore the themes, with verbatim extracts from the interviews supporting the analysis.

Researcher Orientation

The lead researcher DM carried out the study as part of the requirements for a Doctor of Clinical Psychology and has professional experience of working with individuals who self-harm. This experience, as well as noticing a lower up take of community services by males influenced the choice of using IPA, so as to put the Service User experience in the forefront of the research. The other researchers included SL, an academic psychologist, with an interest in the impact of trauma and consequent considerations for service design and delivery; DF, a clinical psychologist specialising in Borderline Personality Disorder and Dialectical Behaviour Therapy; and JK, a consultant liaison psychiatrist based in A & E. The diverse knowledge held by the research team allowed for considered exploration and influenced the recommendations made in this paper.

Ethical Considerations

Important ethical considerations in this study included; verifying informed consent, contacting participants in a non-coercive manner, ensuring confidentiality, and managing possible emotional distress at the time of interview. These factors were addressed by consulting and adhering to the PSI Code of Ethics (PSI, 2011) and University College Cork's Code of Research Conduct (UCC, 2018). This is also in line with the UK Research Integrity Office Guidelines (UKRIO, 2016). Ethical approval was sought and granted by the Ethics Committee of the School of Applied Psychology, UCC (Appendix K; Ethical Approval). Anonymised data will be securely held on an encrypted computer for 10 years after the completion of the study (in line with UCC guidelines).

All participants were given an information sheet and a consent form prior to the study and were made fully aware of what the study entails. There was a risk management plan in place for instances of participants presenting in crisis. Participants were fully debriefed after the interview. They were also given a leaflet containing contact details of relevant support and treatment services.

Analysis

Complete analysis of the data in this study produced 5 superordinate level themes: *Safety and other Service Users; Waiting in the shadows; A compounding of distress; Expectations from experience; and Client-clinician relationships* (Appendix L – Analysis Example). These comprised of a further 11 subthemes (Table 3. Superordinate Themes and Subthemes; Appendix M - Distribution of themes). Pseudonyms have been used throughout to protect the anonymity of the participants.

Table 3. Superordinate Themes and Subthemes

Superordinate Themes	**Subtheme**
Safety and other Service Users	Putting others at risk
	An element of fear
	Feeling exposed
Waiting in the shadows	A shadow in the background
	Risky thoughts; they'd eat you up
A compounding of distress	Like mental health is not an issue
	A monkey in a cage
Expectations from experience	Inpatient; Not going down that road again
	A & E; Knowing the procedure
Client-clinician relationships	Uncertainty without shared information
	A questionable questioning style

Safety and other Service Users

Other people in the waiting room had a range of effects on the participants. While some were fearful of those waiting and what they might do to the participant who was already feeling vulnerable, others were worried for the patrons of the hospital and how they might experience the participant's distressed behaviours. Shame was often an underlying emotion.

Putting others at risk

There's awful trauma going in through there. It's not fair on the other patients either because a person isn't in their right mind going in there. They're confused. Their head's all over the place. They're not mentally right and it's not the place for both the patients in A & E or the nurses. That's not the right environment. (Luke)

Luke's use of '*through'* brings to mind a revolving door of trauma presenting at A & E, but also a process that has to be endured and seen through to the other side. His reflection on the fairness of this process includes both the self and other Service Users. Under such distress he presents as another person and not in his '*right mind'*. Almost implying that the health care services are not designed for people in that state of mind and if so, what would be the 'right mind' to avail of help? He maintains that it is not appropriate for patients, but also includes staff in this quote and may express a hopelessness that he does not fit in any place and is beyond help in A & E.

This next extract demonstrates the fears that another man had about becoming aggressive and lashing out at other Service Users.

I didn't feel one bit safe, do you know what I mean? I'm around these people and I could do anything….. A & E really should have a separate part for someone like myself. They didn't even ask if I felt like harming anyone else…When I was in that frame of mind, I could have felt like harming someone. If someone came in front of me, I probably would have hit them or something. And then they were putting me next to old people and stuff, like. I was saying to myself 'if I blank out here now, there's an old man sitting next to me and I could attack your man like'. (Maurice)

Maurice experienced an unpredictability of the self that was exacerbated by not feeling safe in the A & E environment. It makes sense that one wants to protect oneself when feeling threatened. He looked for some form of validation by asking '*know what I mean?'* and portrays that a lack of safety may be a common experience. Maurice experienced these thoughts as almost intrusive in his heightened state of fear and showed that he did not act on them because he moved from '*probably'* hitting someone in proximity, to being able to sit next to an elderly man. Similarly to Luke, he presented himself as separate and different from the others waiting and conjured up images of '*someone like (himself)'* who was dangerous, volatile, and unpredictable which is in stark contrast to the elderly and possibly vulnerable man. If he were to *'blank out'* it may indicate that he was not responsible for his own actions and some blame could be shifted to the staff for not conducting a thorough enough risk assessment. In reality he was a young man that was hypervigilant of his own internal process due to heightened levels of emotional distress.

Maurice continues to highlight the possible risks to others who are waiting in the same room as him.

They're putting other people at risk by doing that like, not even my own like. They literally are putting other people's lives at risk, like. Even if I was away from everyone else and I felt safe….I might have stayed there. Like obviously I still would have wanted some reassurance about what's going on or whatever but, if I felt safe my mind would have been at ease and I'd have felt more relaxed. I was sitting next to old people and was afraid I'd go mental, like. (Maurice)

The use of repetition emphasises the seriousness of the perceived risk, but he discounts his own safety. He '*literally'* felt there was an imminent risk to life so serious that he had to manage himself by removing himself from the environment. He chose to forego his own care needs after presenting with self-harm in order to prevent possible harm to others. He did not trust his own behaviour and instincts and could not relax. While he did not feel safe, he took the safety of the other Service Users into his own hands which may have served to further heighten his fear. Maurice portrays the terrifying experience in an environment that is inherently fast paced, intense and ever changing. The lack of emotional safety was a turning point in his decision to leave the A & E.

Feeling Exposed

The theme of *Putting others at risk* highlights a fear of being unable to manage and the impact on others. There is also a clear separation of self and others; it could be argued that this 'othering' is exacerbated by the stigma of mental illness. This links with the theme *Feeling Exposed* when seeing other Service Users, which was a common experience for many.

Niall spoke about feeling exposed and on show *'sitting in the middle of the waiting room'* and the shame that this engendered.

If someone needs to go in after cutting their arms, which I've done several times, it's not nice to be sitting in a waiting room with blood coming out of your hands and especially if there are young children sitting there or…little things like that, 'cause it would make the person themselves, they're already feeling like shit anyway, but I think that can make them feel that bit worse if your hand is open and there's bandages around it and children around the area, like do you know? It would make

the patient themselves a bit more comfortable I think, not even a room like, I know that's not possible, but something that you could even pull a curtain across. Not to have them sitting in the middle of waiting room like, where young kids are looking…the embarrassment, and it wouldn't be just the kids either like. Just the embarrassment of it like. The last thing you need is someone looking at you (Niall)

Niall struggled with identifying as the person who was sitting in the waiting room after cutting his arm. He moved from '*someone'* to '*I'* in acknowledging he is the person, but then reverted to using '*they'* and '*the person'* again. This may represent the internal battle he was experiencing of whether to stay or leave. He created a strong, visceral image of the blood coming out of his 'open' hands where he was both literally and figuratively exposed. This was in distinct contrast to the innocence of children. His already heightened state of distress was further compounded by exposing children to such violent imagery. He reached out for empathy and validation by trying to engage the listener with '*like do you know?*'

A compromise of his basic privacy using a '*curtain'* would have been sufficient for him. The repetition of '*embarrassment'* and the mentioning of children, when in fact he means all other people present, emphasises the shame he experienced after an already traumatic incident.

Shame compounded by a lack of privacy had other practical impacts also. Luke spoke about his reluctance to share the full extent of his difficulties with the staff.

I know there's a door there but it's not the place. The porters and everything are there, but it's not their fault. It's only a small room and they usually ask you anyway, 'is it alright if we leave the door open?' everyone knows your business then

like. I just tell them the basics, I'd open up a lot more if it was in across the way (Luke)

It sounds like a forced choice to leave the door open in a situation where the power dynamic is strongly in the staff's favour. The porters are seen as separate from clinical staff and he may have questions about their duty of confidentiality and care. By just telling them the '*basics'* of the sequence of events as opposed to expressions of thoughts and feelings, it makes it very hard for clinical staff to elicit the response needed if they don't have a clear picture of the presenting difficulties beyond the physical cut. This could be why some Service Users perceive that the physical aspect of self-harm management gets prioritised; staff and clients may have different parallel narratives of what occurs in the A & E and there needs to be a middle ground where the barrier of shame is broken down so more meaningful insights into the behaviours can be garnered beyond the physical injury.

An element of fear

There's loads of people around you. You're thinking to yourself 'what's my next move?' (Luke)

In the busy environment, the autonomic stress system (flight or fight response) is activated and Luke has to weigh up the options of whether to stay and possibly be prepared to protect himself against the 'loads of people' or leave and reduce that risk. 'Next move' brings to mind the carefully constructed moves of an elite fighter when confronted in a bout depicting the hospital waiting room as like a war zone as opposed to a medical facility. Eoin describes another element of the fight or flight response; freeze.

You're afraid of your life. Afraid to look left and right. You could see people talking over there and think they're talking about you. A fella might look at you for a few seconds and you're thinking, what the fuck is he looking at me for? What am I after doing to him? The paranoia comes in, the fear comes in. Anxiety comes in. Worry. (Eoin)

He describes being frozen with fear due to paranoid thinking. His presentation was in the context of alcohol misuse and he was worried that he may have done something to the other Service Users in his state of inebriation and that they might be looking for retribution. He is flooded with all forms of fear in a whole-body response, both cognitive and physiological.

Terry goes on to explain further that it is the fear of the unknown with regards to other Service User's thoughts and intentions that creates the most distress.

There's an element of fear and you're trying to deal with what's going on in your own head but you definitely don't have a clue what's going on in their head, you know (Terry)

He contrasts just about being able to 'deal with' his own internal processes against the more definite unknown of the other's thinking. Trying to cope with his own mental state is made more difficult by the unpredictable nature of what thoughts or urges others might be experiencing. This might give some insight into the nature of his internal working model at that point in time.

Michael explained the impact that other people in the waiting room had on him.

It reminds me of staring at my room for hours on end by myself because I don't have too much more to do with my time. But it's even worse when you have

people that are around you that you're like afraid of them because they seem like they are going crazy while sitting there. And I don't want to sit next to these people because they seem like they are even worse off than I am like (Michael)

Here, he describes how the loneliness that is all too familiar to him was exacerbated by the fear he was experiencing at A & E. With comparing levels of emotional distress, could he be describing a type of fear of contagion? Michael presents an image of people in decline '*going crazy while sitting there'*. He doesn't want to sit next to them as he is already struggling and may not have the capacity to protect his personal boundaries. His ability to cope with any more stress has been pushed to its limits.

A compounding of distress

This theme describes the impact that the interpersonal style of hospital security had on their experience at A & E.

Like mental health is not an issue

For some, body language and other nonverbals were enough to make them feel unwelcome at A & E. Terry describes the *'pure arrogant security fuckers'* that he was monitored by. It presents an image of an *us versus them* atmosphere where one party was superior to the other. The use of the expletive is an effort to level the playing field and possibly disrespect them.

Am just pure arrogant security fuckers looking at you like you're a piece of shit like mental health is not an issue, the kind of 'would you not fucking cop on? There's people here who are having heart attacks and fucking strokes and you want to fucking kill yourself! Don't be annoying us, we've fucking better things to be doing' you can see it in their faces like (Terry)

The simile conveys the sense of worthlessness he experienced while being stripped of dignity with a judging look. He was under the impression that his concerns and difficulties were not even valid, and that A & E was not the place for him. It was as if the societal stigma was brought to life for him in a very tangible way. He made a comparison between the treatment of physical health difficulties, that were seen to be severe acute illnesses that are life threatening, and mental health presentations of self-harm and suicidality, that are perceived to be illegitimate in the eyes of the those whose job it is to maintain safety in the hospital. The mental health difficulties are seen to be an annoyance and nowhere near the top of the priority list and could even be alleviated if they decided to *'cop on'* and decide not to have such experiences. All of this is unsaid and interpreted from facial expressions; individuals in such high distress are very vulnerable to misinterpretations. He sees himself as pestering for care and as an inconvenience when he has as much right to care as anyone else who presents to the emergency department.

Terry had experiences in multiple A & E departments and used Siberia and Hawaii to demonstrate the magnitude of variance between the messages given by services in the same region.

*Just the looks and the sheer attitudes of, you know, that's why I was saying about *hospital and *hospital. *hospital is aw, I can't…I can' think of any comparison. Siberia and Hawaii (laughs) right ya, cold as ice, warm and welcoming.* (Terry)

He laughed at the absurdity of it even though it felt real to him. He contrasts the harsh, rejecting attitude with the warm and encouraging atmosphere of the other hospital. Siberia brings to mind the strict regimes of prison camps out in the wilderness and would be seen as a place that you want to escape from, like the

waiting room, while Hawaii brings to a mind a safe haven retreat. Again, all this is unsaid but was interpreted from facial expressions and body language. It highlights the importance of creating a safe environment even before clinical staff are involved.

A monkey in a cage

Being under observation by security while waiting for clinical input left some participants feeling imprisoned.

He was sitting in a chair then, outside the room and how was I going to fall asleep? How was I going to relax? I was like a monkey in a cage like. He sitting down in an arm chair looking in at me. All I needed was someone to talk to. Like the ambulance driver did or the guards did. Do you know what I mean? (Luke)

Luke found it difficult to remain calm and relaxed enough to fall asleep during the long wait. The use of rhetorical questions demonstrates the answers were obvious to him, and he believed, the listener too. The metaphor brings to mind an animal on show in the zoo with people looking at them from a distance for their amusement. Monkeys in a cage are generally chaotic, loud and are often attempting to get out and may reflect how this man felt. Like other participants, he felt dehumanised by his treatment. In contrast to his agitated state, the security guard in an *'arm chair'* seemed more comfortable and at ease. All this man wanted was to connect with another human being in his time of emotional distress and instead was put in a '*cage'*, compounding the isolation he felt. Luke went on to describe the impact that observation and isolation had on him.

You're feel guilty enough about being in the situation in the first place, but you feel fucking ten times worse then and then you come in and you try to come back to normality if you can and you're put in this fucking place. Locked up. What the fuck is

this about like? I'm being really…I felt like I was being…like it was a cry for help or whatever and then I felt like I was being fucking punished there (Luke)

The guilt he felt about self-harming was intensified when he perceived he was being treated like someone who had committed a crime and was being incarcerated. Going to hospital was seen as an effort at getting *'back to normality'* for him, and *'if you can'* may imply that there is some part of him that does not believe that A & E could fulfil this function. It also raises the question of where he was when he was not in '*normality'* and how we can bridge that gap between there and the clinical space of the emergency department without it being too overwhelming a transition.

Luke struggled to find words for a moment and may have been impeded by the shame of admitting that it was a '*cry for help'.* The attempt to illicit care shows his desperation, however he is met with punishment instead of being encouraged to open up about his experience; the punishment being not be facilitated to *'come back to reality'.*

Waiting in the shadows

A common experience for participants was to feel like they were not acknowledged while waiting. This lack of connection meant that some of them were vulnerable to further risky thoughts while sitting in the waiting room.

A shadow in the background

The simile Maurice uses conjures up images of something scary creeping around that is unworthy of care.

'They're not going to do nothing for you. You're only like a shadow in the background. They're just walking past you. Get up and walk out. They're not even making eye contact with you.' (Maurice)

Their shadow form would have no substance to them and be two dimensional in nature with no defining features allowing them to blur in like everyone else. Shadows tend to frighten people and it is the uncertainty of what might be lurking that can be unsettling. Perhaps Maurice is unsure of what form he takes, as just like the shape shifting structure of a shadow, his volatile moods are ever changing and do not allow for a concrete sense of self.

The lack of eye contact confirms his shadow like feelings by not being afforded basic courtesy. He knows that it is the very least he should be getting in terms of care from the health professionals. If they were to '*even'* share a glance together it might reaffirm his dignity.

Another participant shared this view on the need for someone to talk to.

That you'd have someone to talk to. When a person is suicidal, right, they need to talk to someone. That's why Samaritans and all these crowds are there. They need to talk. Not to be isolated. Not to be isolated. You feel guilty enough after what's happened, right, everyone after knowing, but then you feel you're being punished more (Luke)

Luke acknowledges the need to talk to someone, but then emotionally distances himself from the *'suicidal thoughts'* with the use of 'a *person'* and '*they'*. The repetition of '*isolation'* brings it slightly closer to him when the impact of such seclusion hits home. He recognises the '*need'* to talk through his difficulties and does

not present this as simply a preference. However, the guilt he feels for harming himself is compounded by the experience of isolation and lack of connection.

Michael spoke about how a type of connection kept him from leaving the emergency department sooner.

All the nurses that were like trying to keep me there had left at that point, so it had been early in the morning and I'd been waiting so long. I was just saying to myself 'this is so awful', so I just left. I just walked out because anyone that was paying attention to me had left at that point because they were going home or something, but no one else even knew who I was so I just walked home (Michael)

He built some kind of a relationship with the nursing staff while waiting, but then lost the connection and experienced it as quite distressing. This was made worse by the fact that he had been waiting for a significant period of time already at this stage. By the nurses *'paying attention'* to him, he perceived himself to be *seen*, which is an important element in trauma informed care. He possibly felt some responsibility to the nurses to stay despite the long wait as they had been *'trying to keep'* him there. It may be that the nursing staff understood him and helped him to *know* himself in some way. He felt contained when held in mind by the nurses and this changed when that connection was broken due to the changeover of staff.

Risky thoughts; they'd eat you up

Many of the participants spoke about how that lack of connection left them vulnerable to similar thoughts and behaviours that brought them to A & E in the first place. Maurice felt out of place and didn't really know what to do while waiting to be seen and sat there '*twiddling'* his thumbs.

I was sitting there twiddling my thumbs. I kept getting up pacing. I stood there at one point banging my head off the wall hoping they'd come over to me. One nurse seen me. They kept walking past me and when I went in first they were like 'you're next to be seen to see the psychiatrist' and then 4 hours later I was still sitting there. Then all those crazy thoughts came back and I felt really anxious. Like 'what are they doing? They're not going to help you. Just leave. Go away and do it again' So then I left. (Maurice)

Banging his head off the wall is another externalisation of him looking for help. It displays the desperation he was feeling and possibly demonstrates that he did not think he had the language to engage the staff effectively. With the literal acting out of the well-known saying, perhaps he believed the goal of getting the nurse's attention was ultimately hopeless and that he had to manoeuvre his way into care in a way. The nurses walking past him when he expected to be seen left him feeling fobbed off and perhaps wondering if others were worthier of care.

By saying that the *'crazy thoughts came back'* it implies that he returned to the state of distress that he was in before attending. Maurice was suspicious and hopeless and believed that the only alternative to sitting with intense anxiety in this unsafe environment was to leave and self-harm again. He goes on to clarify that the thoughts are more in line with being *'just facts'.*

All them crazy thoughts. They're not even crazy thoughts like, just facts. They just put me in the corner. I know they're busy and stuff, but they could reassure you that you're safe that. Like I was sitting with the unknown, not knowing if by the end of the night whether I'd be safe or not safe. When you sit there not knowing what's going on, it'd eat you up like. It's all thoughts like. (Maurice)

Being put in the corner suggests the *bold corner* from primary school where a child is punished by being made an example of in front of the class. It is often an exercise of embarrassment used to deter a young child from repeating an unwanted behaviour. However here, there sits a young man in a highly distressed state after cutting himself in an effort to regulate his emotions. For him, the thoughts became facts. He doubted them and didn't want to believe them at first, but they were confirmed with the reality of his experience.

'*Sitting with the unknown'* created space for the '*crazy thoughts'* and allowed the generation of many possible scenarios in this ravine. These thoughts could be seen as parasites that take control, '*eat you up'*, and leave you with little choice in leaving or not as it has come down to the basic human drive of maintaining safety.

Niall had a similar experience in that he noticed a decline in his presentation while waiting at A & E.

You're bad enough, you've hit rock bottom and then you're going down this spiral and you say 'oh for fuck sake, it's getting worse.' It made me more anxious if anything. I just said to myself 'feck this, I'm going away', you know (Niall)

He described having to present to the emergency department as a crisis point where he thought he could not get any lower than '*rock bottom'.* However, he offers an image of losing further control of his situation by *'going down this spiral'.* Within this dizzying and confusing experience, it may be that he is already on the downward trajectory when he realises that things have started to unexpectedly disimprove in the very place he thought would help him. Like many others, he couldn't tolerate the anxiety brought by being in A & E so he decided he would better off to take his chances and leave. It may be that A & E gives people a moment of pause to reflect

on their circumstances and this can be overwhelming. Perhaps it is a time when staff could be on alert to changes in presentations.

Lack of meaningful contact also was a risk factor for Terry. The isolation allowed for a return to a familiar style of thinking.

They put me in a room and they left me there for ages and I'd a bandage and I was going 'I could hang myself with that' wrapped it around my neck and tied it to the door thing and just threw my legs out and it was pure coincidence or whatever like, she wasn't, she'd been gone for I don't know a few hours, and just as I threw my legs out she walked in and cut me down. I mean, ha, isolating a person in that frame of mind is not good, amm, it leaves them very vulnerable to their thoughts and back to the thoughts that got them in the situation the first time (Terry)

Like Maurice, Terry felt forgotten about when he was '*put in a room'* out of the way. His decision to harm himself again wasn't on the spur of the moment. He perceived he was left there for a 'few hours' and it sounds like he eventually gave up when he '*threw (his) legs out'.* Perhaps it was difficult for him to keep track of time when he was isolated and distressed, or it may have been a substantial time like he said. He didn't trust the staff to monitor him and believed it to be a '*coincidence'* that the nurse walked in on time.

The thoughts were very real and overwhelming for him in this environment. He recognises that it was a transitory '*frame of mind'* that he was in, but he distanced himself from the attempted hanging after speaking about it previously in the first person when he says, '*a person'* and '*their thoughts'.* Could this be due to shame or feeling that it was a regression to go '*back to the thoughts'* instead of moving forward as he might have expected of a visit to the emergency services?

Eoin spoke about doubting himself while waiting and hoping that the psychiatrist could understand his situation.

You're playing with suicidal thoughts in your head and you don't know whether they're right or wrong. And you don't know whether people are going to believe you or not. You're having a conversation with yourself and the psychiatrist even though the psychiatrist isn't even there. Thinking if he'll believe me. Does he know how bad I really am? What if the doctor had my head for a couple of seconds? Imagine if I could take that out and hand it to the doctor and say 'now, doctor, take a listen to that' (pointing to head/brain). (Eoin)

He reduces the suicidal thoughts to a game in his head. It is suggestive of a cat playing with a mouse; tormenting it and taking away its freedom while giving the mouse the illusion that it has more control. He is unsure of the severity of his suicidal ideation and seems to be unsure of whether to believe himself, like the others may doubt him also. With the use of second person pronouns, there is a distancing from the racing thoughts as he possibly wants to see them as separate from himself.

By having a conversation with himself and the psychiatrist, it implies that Eoin perceives there to be a third person in the discussion that is going on in his head such is the ferocity of his internal dialogue. He doubts that he will be able to vocalise the severity of how he is feeling and would like for the doctor to be able to hold his brain and experience the distress as it will be more powerful than he will be able to communicate. He is asking for others to simply walk in his shoes. By externalising empathy, he wonders if the doctor would even be able to cope with such distress and if not, he definitely would not withhold inpatient admission.

Expectations from Experience

This theme captures the impact that previous attendances at A & E and inpatient admissions had on the participant's decision to leave. They were keen to avoid repeating the past and believed they had learned from previous experiences.

Inpatient; Not going down that road again

Niall spoke of his journey of recovery. He saw inpatient psychiatry as impeding his wellbeing and was keen to avoid it if possible.

*I didn't want to go down that road again, like. I was down that road before [interviewer name], with psychiatry you know. And I didn't like the way I felt when I was on tablets and that so I made my choice that I was going to contact *local counselling service and that's how they came in to it.* (Niall)

By being '*down that road before'* could it mean that he had to work to come back from it and recover from the *recovery system*? The repetition of '*down'* emphasises how he felt on that journey. He made an informed decision to leave the A & E as he considered being on medication worse than experiencing the actual mental health symptoms. He felt empowered to have a choice, in contrast to a system where there are fewer chances for autonomy. He decided to take the direction of his care in to his own hands by going to local counselling instead going '*down that road again'.*

For others there was also a familiarity from past visits to the A & E.

*I know what's coming, there is no help coming. It's going to be *ward, medicate you and fucking…' know what I mean. Why should I prolong my agony? There is no help, there's waiting lists….the only other therapy up there was out*

having a cigarette talking to people who are in the same boat. Because the psychologists or the psychiatrists, whatever they call themselves, come in 'how are ya? bla, bla, bla.' Write a script, medicate you, and off you go (Terry)

Terry first raises the question of what might be provided if help isn't, especially when one would normally associate a hospital with care and help. He answers it himself in staccato fashion which may reflect his perception of how the system is run. By trailing off it is suggestive that he has lost hope in the recovery journey and assumes that the listener knows what he is referring to. The rhetorical question is a very valid one and shows that he understands hospitalisation to be something that will maintain pain and distress instead of relieving it. The repetition of '*no help'* amplifies his hopelessness and is in stark contrast to what is there; waiting lists, cigarettes, and inattentive practitioners.

He flippantly states that a chat with a peer and a cigarette is the only form of therapy offered. However, it may be that he can have a genuine conversation with other Service Users as they are 'in the same boat', which could be the *sinking ship* of the inpatient ward. He is dismissive of what clinicians have to say anymore and suggests that the job titles are only important to the clinician themselves as what they have to say is part of a routine that lacks substance and leads to the same ultimate conclusion of medication anyway.

Terry went to describe what it was like for him when he was medicated and staying on the ward.

I knew I wasn't going to kill myself so I thought why am I hanging around now. They'll put me in a ward again, I'll be walking around like a fucking zombie (Terry)

He felt that his basic safety was in check and perhaps saw A & E as purely a life saving measure that could not offer more support other than admission to an inpatient ward or medication. Maybe the emergency department served the function he was looking for and therefore he left.

Terry's use of language demonstrates the lack of autonomy he felt when '*they'*, seemingly a powerful outside force, '*put'* him in the ward. He creates a strong image of being like the walking dead while on medication; there in body, able to walk around, but with no quality of life, purpose or meaning. It is evocative of rotting away slowly, while being stripped of humanity and soul, and left as simply physical matter.

He sees an inpatient admission as the next step following a presentation to A & E. It could be useful to provide some education as to the alternatives, given the perception he has of being turned in to a monster on the ward.

A & E; knowing the procedure

While some participants spoke about the consequences of being admitted following previous presentations to A & E, others detailed past experiences they had in A & E itself and the impact that these had on their decision to leave. For one repeat attender there was a lot of embarrassment associated with looking for care again.

Here we go again. Doing doctor's thinking, doing nurse's thinking. I suppose I was thinking like, in a way like, 'fuck it, they're sick of me'. I was doing their thinking like. I'd even be looking at nurses inside and I'd be hiding from them because I'm here again. It's like a merry go round, like a rollercoaster I was on (Eoin)

The A & E was something that was all too familiar to Eoin and he felt exasperated by it starting '*again'*. By 'doing' the clinician's thinking it sounded like

something automatic that he had little control over, however, he then takes ownership over thoughts with some hesitation. He recognised that he felt like a burden and assumed the staff believed the same. This led to overt shame related behaviour by '*hiding from them'* and getting caught in the cycle. It escalated from the gentle '*merry go round'* to the more severe twists and turns of a '*rollercoaster'* and this might be indicative of the revolving door of care without resolution to his problems.

Luke explained how the fear from a previous presentation at the hospital dominated his experience and caused him to be confronted with more distress on arrival.

I know the procedure. They're going to put me in here and when I go in that door the security will be there. Boxed in. I was getting more agitated. I was getting worse actually…I was thinking and I was thinking and I was thinking. The secretary came out and said, 'she'll be down shortly'. And I said I went away home, I knew the procedure (Luke)

He prompts a claustrophobic image of being 'boxed in' and watched by security as if he had been arrested. He emphasises how much worse he was getting with the use of repetition and reveals that he took time to decide to leave without making an impulsive decision; '*I was thinking and I was thinking and I was thinking'.* He made up his mind that he'd seen enough of A & E before and could not face being '*boxed in'* again, so retreated to the safety of his home.

While some were fearful of previous attendances, others detailed a more hopeless outlook due to what they learned from experience.

I felt like they were just keeping me there. They were trying to make sure I wasn't going to hurt myself again, but I didn't want to. I just wanted to go home. I think I've already talked to doctors so many times and I have had therapists and stuff and like, I was waiting there for 8 hours and the doctor isn't going to give me anymore of a perspective that I don't already have. Or already gotten from my own therapists (Michael)

Michael felt that he was being kept waiting purely for risk management reasons. Perhaps they were overly cautious and if the risk was understood as a changing entity he may have been encouraged to go home. He expresses a hopelessness about gaining any new '*perspectives'* on his mental health difficulties and seems to be worn out from the system of doctors and therapists. Waiting another few hours on top of an already significant period could not be rewarded sufficiently enough by old information. He describes how the professionals '*give'* him the insight instead of him arriving to those conclusions himself and possibly reflects a dependent nature, but also may highlight how he experiences the mental health services as *doing to* instead of *being with* on his recovery journey.

Client-clinician relationships

Uncertainty without clear information

Many participants mentioned difficulties they had with not receiving clear information while they were waiting to be seen. This led to confusion and uncertainty and did not foster an atmosphere of physical or emotional safety.

I know they're busy and things but it would only take two minutes to come over and even if it was every five minutes and say 'oh, someone else came in that's in a worse condition than you we have to deal with them'. That'd be fair enough like,

but when I came in first, she told me I was next to be seen…maybe not even a separate room, but not leave a fella sitting in the corner. I went in and was told I was next so was thinking maybe 20 minutes, half an hour but none of that. I'd have said 'ya, no problem', if she actually told me I'd be waiting. (Maurice)

Maurice recognises the busyness of the A & E and the need for prioritising different emergencies, but still would like regular updates. These are especially important to him when expectations are not. Similar to other participants, being left '*sitting in the corner'* was more of an issue than the wait itself. It is suggestive of being put out of the way, forgotten about, or even punished. He describes not expecting too much, only what he perceived to be fair, given the demands on frontline staff. He goes on to describe why clear information is especially important in cases of self-harm.

If you went to hospital with a broken leg and you were sitting there for hours, well, that's different. But when you're brought in after cutting yourself, or whatever, and you're sitting there, your mind is going crazy….With a wait for a broken leg you know you're going to get a cast. So, like after this, you don't know what's going on or what's going to happen to you or where you're going to go. (Maurice)

In this extract, Maurice compares certainty with uncertainty. Although a broken leg and self-lacerations are both physical injuries, the causes and underlying psychological pain is different. A cast can contain the broken leg and the emotion around it, but the participant knows that he cannot get a cast for his racing '*crazy'* thoughts. The lack of certainty in what is coming next fuels the racing thoughts and leads to a perception of possible things being *done to* or being brought to unknown

places. It hints to an absence of participation in the care and leaves the participant misinformed, which only serves to heighten his distress and anxiety.

Terry acknowledged that clinicians have to do certain aspects of their job, but he also would have preferred clearer information to help him feel safe.

I fully understand that it's procedural and that they're busy and they need to get the information from to make you better and follow the next steps, but at the end of the day it's you that's lying there not knowing if you tried to commit suicide last night.…just a few bits of information saying look you're ok now but we're going to have the psychiatrist have a look at you because you mentioned a few things about wanting to die. That would have kept me in A & E on Christmas day. She was looking at me and I don't know, I was just after waking up (laughs), so I unhooked and ran (Terry)

He realises that the staff still have to follow certain steps but would like if there was more recognition of the vulnerable position of the client after seriously harming themselves due to heightened emotional dysregulation. There is inherent helplessness in lying down with people looking over you, and this would be exacerbated when you wake up in a hospital setting without knowing how you got there. An explanation of what is coming when they '*follow the next steps'* is important instead of assuming the individual knows. Clear communication would remove the possibility of *mind reading* and may facilitate a shared narrative of events.

A questionable questioning style

When the participants eventually were seen, some had concerns around how the clinicians gathered information. There was a mixture of direct, warm, and limited questioning. Terry described being treated like the suspect of a crime where the only

goal of the interaction was to obtain information, to the detriment of developing rapport or building the relationship.

Questioned very fucking procedurally and clinically. 'How are you feeling? Are you going to kill yourself tonight? Are you going to attempt suicide? We need to take your belt, we need to take your shoes, and we need to take this off you. They question you like you're in a Garda station. (Terry)

The expletive is used to express disapproval of such a perceived forceful questioning style. It is clear that risk management was a top priority for the clinician, however, little regard was given to the individual when he was literally stripped of his dignity by removing some of his clothes. He goes on to describe an alternative approach to the interview.

One of the first questions they ask is 'so you have suicidal thoughts, yes. Why didn't you commit suicide?' and you kinda go, your first thought is 'fucking hell, I can't even get that right! (laughs)' I can see why they ask like… but it's compounding how useless you are and why would you want to be alive…so why didn't you kill yourself could be rephrased to why have you presented yourself here today and sought help instead of why didn't it fucking work for you (laughs) (Terry)

Terry uses humour to deflect from the shame of feeling incompetent. He suggests that when the question is phrased negatively, it is more difficult to propose protective factors. '*Kill yourself*' underscores the harshness of how they ask it and is contrasted with the gentler suggested approach. This extract highlights the risk management nature of the work in crises and how a more therapeutic response can be forgotten about when under pressure and wanting to keep people alive.

In comparison to the direct questioning style, comes the contrasting approach by one nurse to focus purely on the physical injury and neglecting to treat the person as a whole.

There was no interaction really. She wasn't even talking to me. She just cleaned them really. Even though she was only a nurse, if she just had a small chat like that would have been, would have made it a bit less….if she just said 'oh, how are you?' small chat, you know. (Maurice)

There are similar procedural elements here that others have pointed out also. Short pieces of conversation or general niceties when interacting with someone normally would put them at ease. Maurice could not find the word for how it made him feel ('*would have made it a bit less…*') but he knows that he wanted something different. It may have helped him to see himself as a person separate to the wounds he was presenting with.

Michael had two contrasting styles of clinician interaction and was able to reflect on which one put him more at ease. He could get a feeling for when a clinician was genuinely engaged or just following procedure by asking '*generic questions'.*

Some of them I really did not want to answer them, but others were talking to me directly and trying to understand me, but others were asking me really generic questions that I just didn't want to answer. The guy I was telling you about was just sitting there talking to me as if I was a friend of his and wasn't just giving me generic questions that psychologists have to ask and stuff…just talking to me like a human being (Michael)

The generic questions possibly deindividualize the interaction for the Service User and give them the impression that the clinician is just gathering information

instead of trying to '*understand'*. It may feel like more of a *tick the box exercise* that can be devoid of empathy. This is contrasted with the genuineness and congruence in the other interaction where he was not being treated as a symptom of self-harm that needs to be measured, but as a 'human being' with emotions, fears, and hopes. It sounded more like a reciprocal conversation instead of one-way questioning.

Discussion

While there has been much research into the experience of care at A & E for self-harm and some limited quantitative research examining the profile of those who leave before next care recommendations can be made, to the authors' knowledge this is the first study exploring the reasons for such self-discharge. The themes that emerged from the interviews demonstrate that there are a variety of reasons for leaving A & E without receiving the appropriate next care recommendations. There was a combination of internal and external barriers which prevented the men from staying in line with medical advice. Some of the internal barriers included negative emotions such as fear, shame, and guilt, and the associated cognitive and behavioural processes that accompany such emotions. The aspects external to the person that lead them to leave early included the impact of other Service Users in the waiting room, the presence of security staff, and the style of interaction employed by the clinicians.

Previous research has indicated that men who are city residents, or homeless, aged between 25 and 44, presenting with drug overdose or attempted drowning are most likely to leave A & E before it is recommended (Arensman et al., 2018). Our sample was representative of this population. However, now we have a sample of qualitative responses to this problem instead of the speculation that surrounded it, which included queries regarding the possibility of having social responsibilities elsewhere or fear of medical procedures (Crowder et al., 2004). The impact of alcohol and drug use on early self-discharge was also considered to be a driving factor in the decision process (Barr et al., 2004; Horrocks et al., 2002). While alcohol was present for some of the participants in this study, there were overwhelmingly numerous other reasons cited for leaving. It is interesting to note that

previous studies sought to explain the self-discharge with factors related to the Service User and almost never with factors related to the service. The current study reveals a combination of both.

When comparing to the research base on general attitudes to A & E for self-harm, there are some shared experiences. In relation to the superordinate theme of *Safety and other Service Users*, O' Connor (2015), Cerel, Currier & Conwell (2016), and Owens et al. (2016) reported that other individuals in the waiting room negatively impacted on emotions such as shame and guilt due to the perceived divide between those that were there for self-harm and those presenting for physical illnesses. A lack of privacy that compounded feelings of anxiety and shame has been reported in previous studies also (Horrocks et al., 2005; Palmer et al., 2007, Suominen et al., 2004). However, an actual fear of other Service Users and concern for them did not arise in previous literature as it did in the current study. Participants described a heightened sensitivity to their own autonomic stress response and a suspiciousness and fear of those also waiting to be seen. These overwhelming emotions were maladaptively self-regulated by leaving the environment in which they were exacerbated.

Exposure to threat has long been understood to stimulate sympathetic hyperarousal and parasympathetic hypoarousal in the autonomic nervous system (ANS) resulting in fight, flight, or freeze (LeDoux, 2002; Ogden et al., 2006; Van der Kolk, 1996). Therefore, threatening and traumatic incidents can produce a wide range of physiological, emotional, and cognitive symptoms. With such dysregulation, individuals struggle to tolerate it without becoming overwhelmed (Ogden et al., 2006). In the current study, the decision to leave can be understood to be part of this process, as well as the continuing urges to self-harm. This overwhelm can lead to

inhibition of cortical activity (LeDoux, 2002) which is associated with disinhibition and lack of impulse control. For most of the participants there did not seem to be a consideration of what supports may be needed once they left A & E. Perhaps, if Distress Tolerance skills from Dialectical Behaviour Therapy could be implemented in this acute setting it may help those that want to leave to sit with their discomfort until it was time to see the clinicians. One participant also made the suggestion to have volunteers, like The Samaritans, available in the A & E.

Trauma Informed Care (The Substance Abuse and Mental Health Services Administration; SAMHSA; 2014) is another perspective that could be taken to foster principles of safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural competence in the A & E. A trauma informed service accommodates such dysregulation and views people as presenting with adaptive responses as opposed to ‘challenging behaviour’. This facilitates environments of compassionate care and reduces stigma and bias (Huckshorn, & LeBel, 2013).

Linked to the cognitive dysregulation due to activation of the ANS are cognitive distortions. They are defined as ‘errors in both cognitive processing and content that result in maladaptive or unhelpful interpretations of incoming stimuli’ (Alford and Beck, 1997, p. 36). It could be posited that these distortions played a role in the decision process to leave the A & E in terms of attributing malignant intentions to others in the waiting room, assuming non-clinical staff bear strong negative judgements, or that clinicians do not have their best interest in mind, among others. They possibly amplified already negative thoughts and emotions. However, this does not negate the experiences that these men encountered.

A lack of connection and a sense of isolation in the A & E following presentations for self-harm has been a reported experience for many others outside of this study (Horrocks et al., 2005; Cerel, Currier, & Conwell, 2006). This disconnect served to increase emotional dysregulation and at times left the Service User with urges to leave the A & E (O' Connor, 2015). Perhaps the population who leave are those that cannot tolerate the isolation. Hunter et al. (2013) and Owens et al. (2016) described how regular check-ins by staff allowed individuals to believe they are worthy of care, thus recovering a sense of self-worth and creating a positive experience of care at A & E (Palmer et al., 2007). Participants in this study also detailed how brief check-ins by staff would be beneficial. Although, this was often lacking and left them vulnerable to similarly risky thoughts and urges that made a visit to A & E a necessity in the first place. Participants described how they took it into their own hands by leaving when they did not feel safe in the environment.

The impact of security on the decision process to leave is an important finding from the study and to the authors knowledge has not been considered in previous research. The dynamic of *prisoner versus guard* felt very real to some participants and compounded already heightened experiences of guilt and shame. In a study of A & E workers' perceptions of security guards' effectiveness (Gillespie, Gates, Miller, & Howard, 2012) participants shared varied views on the role of security. Some clinicians believed that the involvement of security led to an escalation of violence in the setting as it gave the message that they were *'putting our foot down and saying you're going to do it our way'* (Gillespie, Gates, Miller, & Howard, 2011, p. 24). It may be beneficial to increase awareness of the impact of stigma against mental health difficulties through specific training for non-clinical staff.

Previous experiences at A & E having an impact on the most recent visit have been reported in other research (Palmer et al., 2007; Taylor, 2003; Owens et al., 2016). However, there appears to be a significant finding in the current study given that participants described the influence of negative inpatient admissions on their decision to leave before advised. It would be interesting to examine the rates of previous inpatient admissions for a larger sample of this population. Participants in other studies have commented on a lack of control and a sense of being punished whilst being an inpatient for self-harm (Brophy, 2006). Similar to the participant who stated that the '*other therapy up there was out having a cigarette talking to people who are in the same boat',* others held the same view that they did not get the opportunity to engage in therapy for their self-harm on the ward (Rolfe, 2002). Psychoeducation on the other possible interventions for self-harm may be beneficial to Service Users who may assume that an inpatient admission is always the next step.

Similarly to findings on general experiences of care for self-harm at the A & E (Hunter et al., 2013; Horrocks et al., 2005; Owens et al., 2016), the participants in this study described how their interactions with staff were often less than satisfactory due to a lack of clear shared information. It often led to confusion and uncertainty about what was going to happen next in the busy environment. In contrast to this style of interaction, participants in the current study reported that regular updates about wait times would have helped to decrease the anxiety brought about by uncertainty and facilitated them to stay.

A systematic review (Rees et al., 2014) of the literature on emergency care staff's attitudes towards those who present with self-harm concluded that they held negative perceptions, and this was attributed to insufficient training and knowledge of

how to manage the psychological needs of these Service Users. There is some research currently in press (Burke et al., 2019) examining A & E clinicians' perceptions of a training that they received for working with individuals presenting with severe emotional dysregulation. *Clinician Connections* is based on the *Family Connections* programme and Dialectical Behaviour Therapy which have proven effective for those presenting with self-harm (Fruzzetti & Hoffman, 2004). Clinicians identified further training needs, but there is early qualitative evidence to suggest that training on validation techniques helped to build rapport with individuals and fostered a confidence in the clinicians to be able to work more effectively with those presenting with self-harm and emotional dysregulation. This may be what is needed when there are a significant number of individuals leaving A & E every year due to not feeling seen and heard.

Limitations

As IPA is an interpretive process by nature, it was important to maintain an audit trail of the analysis to maintain transparency and validity (Yardley, 2000). This facilitated the author to recognise any preconceptions about the subject which may have impacted on the analysis (Appendix M – Reflexive Statement; Appendix O-COREQ; Consolidated criteria for reporting qualitative studies: 32-item checklist). The knowledge developed through this study is not presented as an absolute truth, rather an interpretation of the experiences of the participants, developed using a recognised framework. The data relied on participants' recall of interactions with the hospitals concerned and memory and perception can be faulty and are inevitably influenced by the passage of time. While there were recruitment difficulties in this hard to reach population, the homogenous sample allows for the findings to be theoretically generalised within this population (Smith et al., 2009).

Future Research and Clinical Implications

It would be interesting to access the feasibility of system wide trauma informed care and to implement it following training if possible (Appendix Q – Future Research and Clinical Recommendations). This could involve follow up studies on the perception of care and the level of self-discharge under the new model. Under the current system, it would be beneficial to explore the perception and understanding of A & E staff of those that leave and to examine if there are shared areas of misunderstanding that could be addressed. In a similar vein, exploring the views of females who leave before recommendations can be made would add further insight into this phenomenon. On a more practical level, implementing an initiative where voluntary services are given a small space near the waiting room to facilitate supportive listening may prove helpful in encouraging people to wait to be seen. Giving choice regarding privacy and allowing the individual to decide if they want to wait in the general waiting room or in a more secluded area also seemed to be important for participants in this study and may be something to consider in the future.

Conclusion

There are a significant number of men who self-harm that leave the A & E every year before they can receive appropriate next care recommendations. It is impossible to stop every one of these, but there are certainly steps that can be taken to reduce the chances of it happening. Training for clinical and non-clinical staff on the reasons why men struggle to wait in accident and emergency can increase awareness of the issues involved and changes to service delivery can mitigate the current high levels disengagement.

References

Alford, B. A., & Beck, A. T. (1997). The integrative power of cognitive therapy. New York, NY: Guilford Press.

Appleby, L., Shaw, J., Amos, T., *et al.* (1999). *Safer Services. Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health.

Arensman, E., et al. (2013). Factors associated with self-cutting as a method of self-harm: Findings from the Irish National Registry of Deliberate Self-Harm. European Journal of Public Health. 24(2): 292-7.

Arensman, E., Griffin, E., Daly, C., Corcoran, P., Cassidy, E. & Perry, I.J. (2018). Recommended next care following hospital-treated self-harm: Patterns and trends over time. PLoS ONE 13(3): e0193587.

Barr, W., Leitner, M. & Thomas, J. (2005). Psychosocial assessment of patients who attend an accident and emergency department with selfharm. Journal of Psychiatric andMentalHealthNursing 12, 130–138.

Bennewith, O., Gunnell, D., Peters, T.J., Hawton, K., House, A., (2004). Variations in the hospital management of self harm in adults in England: observational study. BMJ 328, 1108–1109.

Bergen, H., Hawton, K., Waters, K., Cooper, J., Kapur, N. (2010). Epidemiology and trends in non-fatal self-harm in three centres in England: 2000-2007. British Journal of Psychiatry, 197, 493-498.

Boudreaux, E.D., Miller, I., Goldstein, A.B., Sullivan, A.F., Allen, M.H., Manton, A.P., Arias, S.A. & Camargo, C.A. (2013). The Emergency Department Safety

Assessment and Follow-up Evaluation (ED-SAFE): Methods and design considerations. Contemporary Clinical Trials;36:14–24.

Brophy, M. (2006). Truth Hurts: Report of the National Inquiry into Self-Harm among Young People. Mental Health Foundation.

Burke, L., Kells, M., Flynn, F. & Joyce, M. (2019). Exploring staff perceptions of the utility of Clinician Connections when working with emotionally dysregulated clients. Manuscript submitted for publication.

Bywaters P. & Rolfe, A.. (2002) Look beyond the scars: Understanding and responding to self-injury and self-harm. NCH.

Cerel, J., Currier, G. W., & Conwell, Y. (2006). Consumer and Family Experiences in the Emergency Department Following a Suicide Attempt. Journal of Psychiatric Practice, 12(6), 341–347.

Chapman, R. & Martin, C. (2014). Perceptions of Australian emergency staff towards patients presenting with deliberate self-poisoning: a qualitative perspective. Int Emerg Nurs; 22: 140–5.

College of Psychiatrists of Ireland. (2016) National Clinical Programme For the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm. Dublin. College of Psychiatrists of Ireland.

Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway- Jones, K., Appleby, L. (2005). Suicide after deliberate self-harm: a cohort study. American Journal of Psychiatry 162, 297–303.

Crowder, R., Van Der Putt, R., Ashby, C., *et al* (2004). Deliberate self-harm patients who discharge themselves from the general hospital without adequate

psychosocialassessment. *Journal of Crisis Intervention and Suicide*, 25, 183–186.

Department of Health. (2002). National suicide prevention strategy for England. London: Department of Health.

Ford, J. (2018). Complex Trauma and Developmental Trauma Disorder in Adolescence. *Adolescent Psychiatry*, *7*(4), 220-235.

Fortune, S., Sinclair, J. & Hawton, K. (2008). Adolescents' views on preventing selfharm. Social Psychiatry and Psychiatric Epidemiology, 43, 96–104.

Fruzzetti, A. E., & Hoffman, P. D. (2004). Family Connections: Workbook and training manual. Rye, NY: National Education Alliance for Borderline Personality Disorder.

Gee, J. P. (2005). An introduction to discourse analysis: Theory and method (2nd ed.). London: Routledge.

Gillespie, G. L., Gates, D. M., Miller, M., & Howard, P. K. (2012). Emergency department workers' perceptions of security officers' effectiveness during violent events. *WORK: A Journal of Prevention, Assessment, & Rehabilitation, 42*(1), 21-27.

Griffin, E., Dillon, C., O'Regan, G., Corcoran, P., Perry, I., & Arensman, E. (2017). The paradox of public holidays: Hospital-treated self-harm and associated factors. *Journal Of Affective Disorders*, *218*, 30-34.

Griffin, E., Dillon, C.B., McTernan, N., Arensman, E., Williamson, E., Perry, I.J. & Corcoran, P. (2018). National Self-Harm Registry Ireland Annual Report 2017. Cork: National Suicide Research Foundation.

Harris, E.C. & Barraclough, B. (1997). Suicide as an outcome for mental disorders. A meta-analysis. Br J Psychiatry 170:205–228.

Haw, C. & Hawton, K. (2008). Life problems and deliberate self-harm: associations with gender, age, suicidal intent, psychiatric and personality disorder. Journal of Affective Disorders, 109, 139–148.

Haw, C., Hawton, K., Houston, K., et al. (2001). Psychiatric and personality disorders in deliberate self-harm patients. British Journal of Psychiatry, 178, 48–54.

Hawton, K. (1998). A national target for reducing suicide. Important for mental health strategy as well as for suicide prevention. BMJ; 317:156e7.

Hawton, K., Rodham, K., Evans, E., et al. (2002). Deliberate self-harm in adolescents: self report survey in schools in England. British Medical Journal, 325, 1207–1211.

Hickey, L., Hawton, K., Fagg, J., Weitzel, H. (2001). Deliberate selfharm patients who leave the accident and emergency department without a psychiatric assessment. A neglected population at risk of suicide. Journal of Psychosomatic Research 50, 87–93.

Horrocks, J., Hughes, J., Martin, C., House, A., & Owens, D. (2005). Patient experiences of hospital care following self-harm - A qualitative study. Leeds: University of Leeds.

Huckshorn, K. & LeBel, J. L. (2013). Trauma-informed care. Modern community mental health work: An interdisciplinary approach, 62-83.

Hughes T., Hampshaw S., Renvoize E. & Storer D. (1998). General hospital services for those who carry out deliberate self-harm. *Psychiatric Bulletin* 22, 88–91.

Hunter, C., Chantler, K., Kapur, N., & Cooper, J. (2013). Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking: A qualitative study. Journal of Affective Disorders, 145(3), 315–323.

Isacsson, G. & Rich, C.L. (2001). Management of patients who deliberately harm themselves. BMJ;322:213-215.

Kapur, N., House, A., Creed, F., Feldman, E., Friedman, T., Guthrie, E., (1998). Management of deliberate self-poisoning in adults in four teaching hospitals: descriptive study. BMJ 316, 831–832.

Kapur, N., Murphy, E., Cooper, J., Bergen, H., Hawton, K., et al. (2008). Psychosocial assessment following self-harm: results from the multi-centre monitoring of self-harm project. Journal of Affective Disorders 106: 285–293.

Karman, P., Kool N., Poslawsky, I.E., & Van Meijerl, B. (2015). Nurses' attitudes towards self-harm: a literature review. Journal of Psychiatric and Mental Health Nursing, 22, 65-75.

LeDoux, J. (2002). The Synaptic Self: How our Brains Become Who We Are. New York: Guilford Press.

McHale, J., & Felton, A. (2010). Self-harm: what's the problem? A literature review of the factors affecting attitudes towards self-harm. Journal of psychiatric and mental health nursing, 17(8), 732- 740.

Middleton, N., Whitley, E., Frankel, S., Dorling, D., Sterne, J. & Gunnell, D. (2004). Suicide risk in small areas in England and Wales, 1991–1993. Soc Psych Psychiatr Epidemiol 39:45–52.

Murphy, G. (2000). Psychiatric aspects of suicidal behaviour: substance abuse. In: Hawton K, Van Heeringen K (eds) The International handbook of suicide and attempted suicide. Wiley, Chichester, pp 135–146.

Murray, C.J., Vos, T., Lozano, R., et al. (2012). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2012: a systematic analysis for the Global Burden of disease Study 2010. Lancet; 380:2197–223.

O' Connor, S. (2015). Experiences of the relationship between hospital staff and people who self-harm by. Unpublished

Ogden, P., Minton, K. & Pain, C. (2006). Trauma and the body: a sensorimotor approach to psychotherapy. New York: Norton.

Owens, C., Hansford, L., Sharkey, S. and Ford, T. (2016). Needs and fears of young people presenting at accident and emergency department following an act of self-harm: secondary analysis of qualitative data. *British Journal of Psychiatry*, 208(03), pp.286-291.

Owens, D., Horrocks, J. & House, A. (2002). Fatal and non-fatal repetition of self-harm: systematic review. The British Journal of Psychiatry 181: 193.

Palmer, L., Strevens, P., & Blackwell, H. (2006). Better Services for People who Selfharm: Data Summary - Wave 1 Baseline Data. London, Royal College of Psychiatrists.

Perry, I.J., Corcoran, P., Fitzgerald, A.P., Keeley, H.S., Reulbach, U. & Arensman, E. (2012). The incidence and repetition of hospital-treated deliberate self harm: findings from the world's first national registry. PLoS ONE, 7(2):e31663

PSI (Psychological Society of Ireland). (2011). Code of professional ethics. http://www.psychologicalsociety.ie/board-of-professional-conduct

Rees, N., Rapport, F., Thomas, G., John, A. & Snooks, H. (2014). Perceptions of paramedic and emergency care workers of those who self harm: A systematic review of the quantitative literature. *Journal of Psychosomatic Research*, **77**, 449– 456.

Royal College of Psychiatrists (2004). Assessment following self-harm in adults. Royal College of Psychiatrists, London.

Royal College of Psychiatrists. (2010). Self-harm, Suicide and Risk: Helping People who Self-harm (Council Report 158). London: Royal College of Psychiatrists.

Sinclair, J., Gray, A. & Hawton, K. (2006). Systematic review of resource utilization in the hospital management of deliberate self-harm. Psychological Medicine 36: 1681–1693.

Slee, N., Garnefski, R., van der Leeden, R., et al. (2008). Cognitive-behavioural intervention for self-harm: Randomised controlled trial. The British Journal of Psychiatry, 192, 202–211.

Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.), Qualitative Psychology: A Practical Guide to Methods (pp. 53-80). London: Sage.

Smith, J. A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J. Smith, Qualitative Psychology: A Practical Guide to Research Methods (pp. 53-80). London: Sage.

Smith, J.A., Flowers, P. & Larkin, M. (2009). Interpretative phenomenological Analysis: Theory, Method, Research. London: Sage.

Spinazzola, J., van der Kolk, B., & Ford, J. (2018). When Nowhere Is Safe: Interpersonal Trauma and Attachment Adversity as Antecedents of Posttraumatic Stress Disorder and Developmental Trauma Disorder. *Journal Of Traumatic Stress*, *31*(5), 631-642.

Substance Abuse and Mental Health Services Administration (SAMHSA). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: substance Abuse and Mental health Services Administration, 2014. http://store.samhsa.gov

Suominen, K., Isometsä, E., Henriksson, M., Ostamo, A., & Lönnqvist, J. (2004). Patients' evaluation of their psychiatric consultation after attempted suicide. Nordic Journal of Psychiatry, 58(1), 55–59.

Taylor, B. (2003). Exploring the perspectives of men who self-harm. Learning in Health and Social Care, 2(2), 83–91.

Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J.A. & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses. Clinical Psychology Forum, 108, 3-7.

UK Research Integrity Office Guidelines (UKRIO); Promoting good practice and preventing misconduct (2016).

University College Cork (UCC); Code of Research Conduct. (2018).

Van der Kolk, B.A. (1996a). The complexity of adaptation to trauma: self-regulation, stimulus discrimination, and characterological development. Traumatic Stress: the Effects of Overwhelming Experience on Mind, Body, and Society. New York: Guilford Press, 182–213.

Whitehead, L., (2002). Therapeutic aspects of the psychosocial assessment following overdose. Dissertation for the degree of Master of Science in Mental Health. Oxford Brookes University, Oxford.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health* 15: 215–228.

Zahl, D. & Hawton, K. (2004). Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11,583 patients. The British Journal of Psychiatry 185: 70–75.

Appendix A - Quality assessment of qualitative studies using CASP

	Harris (2000)	Horrocks, Hughes, Martin, House & Owens (2005)	Hunter, Chantler, Kapur, & Cooper (2013)	O' Connor (2015)	Owens, Hansford, Sharkey, & Ford (2016)	Taylor (2003)	Walker (2017)
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes	Yes	No	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Were the data collected in a way that addressed the research question?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Has the relationship between researcher and participants been adequately considered?	No	No	Yes	Yes	No	No	Yes
Have ethical issues been taken into consideration?	No	No	Yes	Yes	Yes	No	Yes
Was the data analysis sufficiently rigorous?	No	Yes	Yes	Yes	Yes	No	Yes
Is there a clear statement of findings?	No	Yes	Yes	Yes	Yes	Yes	Yes
Strength	Acceptable	Strong	Strong	Strong	Strong	Weak	Strong

Appendix B - Quality assessment of descriptive quantitative studies using MMAT

	Haw, Hawton, Whitehead, Houston & Townsend (2003)	Suominen, Isometsä, Henriksson, Ostamo, & Lönnqvist (2004)
Is the sampling strategy relevant to address the research question?	Yes	Yes
Is the sample representative of the target population?	Yes	Yes
Are the measurements appropriate?	Yes	Yes
Is the risk of nonresponse bias low?	Yes	Yes
Is the statistical analysis appropriate to answer the research question?	Yes	Yes
Strength	Strong	Strong

Appendix C - Quality Assessment of mixed method studies using MMAT

	Cerel, Currier, & Conwell (2006)	Palmer, Strevens, & Blackwell (2006)
Is there an adequate rationale for using a mixed methods design to address the research question?	Yes	No
Are the different components of the study effectively integrated to answer the research question?	Yes	Yes
Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes	No
Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	No	No
Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Yes	Yes
Strength	Acceptable	Acceptable

Appendix D - Themes present in each study

	Cerel, Currier, & Conwell (2006)	Harris (2000)	Haw, Hawton, Whitehead, Houston & Townsend (2003)	Horrocks, Hughes, Martin, House & Owens (2005)	Hunter, Chantler, Kapur, & Cooper (2013)	O' Connor (2015)	Owens, Hansford, Sharkey, & Ford (2016)	Palmer, Strevens, & Blackwell (2006)	Suominen, Isometsä, Henriksson, Ostamo, & Lönnqvist (2004)	Taylor (2003)	Walker (2017)
Negative Staff Attitudes	✓	✓	-	✓	✓	✓	✓	✓	✓	-	✓
Judgement	✓	✓	-	✓	✓	-	✓	✓	✓	-	✓
Unpredictability	-	-	-	-	✓	✓	-	-	-	-	-
Staff not engaged	-	-	-	✓	✓	✓	✓	-	-	-	-
An unsuitable physical environment	✓	-	-	✓	-	✓	✓	✓	✓	✓	✓
PH V MH	✓	-	-	-	-	✓	✓	-	-	-	-
Logistics of the Environment	✓	-	-	✓	-	✓	-	✓	✓	✓	✓
I**nner turmoil / Experience**	✓	✓	✓	✓	-	✓	✓	-	-	✓	✓
Negative emotions	✓	✓	✓	✓	-	✓	✓	-	-	✓	✓
What is deemed helpful	-	-	✓	✓	✓	✓	✓	✓	-	-	✓
Regular check ins	-	-	-	✓	✓	✓	-	✓	-	-	-
Distress recognised	-	-	✓	-	✓	-	✓	-	-	-	✓

Appendix E - Themes and example data

Theme	Subtheme	Data
Negative Staff Attitudes	Judgement	'they judge you if you're an addict, it's on your notes, you get terribly judged' (Hunter et al., 2013 p.319) *'Because I have been seen at this A & E on a number of occasions I feel very judged by the staff and they have a negative attitude towards me. It's as if they are thinking 'not her again'.'* (Palmer et al. 2007, p.14) 'they wouldn't touch me…they looked at me as if to say 'I'm not touching you in case you flip'..they didn't actually say it but it was their attitude…but there again I can understand nurses being a bit scared.' (Horrocks et al., 2005, p.12)
	Unpredictability	'Sometimes the staff are like really, really nice to you and really reassuring and then other times they'll be really, sort of belittle you…they can be a bit like horrible' (O' Connor, 2015, p.57)
	Staff not Engaged	'It's one of those things isn't it, he's got to ask it, just to cover himself' (Hunter et al., 2013, p.318) 'Some doctors seem to think there is a relationship between self-harm and not being able to hear, so they don't bother addressing you but just talk to anyone who happens to be with you' (Owens et al., 2016 et al., p.288) 'You treat me like I've just walked in from a flat up the road and this is like a hobby for me; it's not' (O' Connor, 2015 p.60).
An Unsuitable Physical Environment	PH V MH	'Cause if like someone came in with a broken leg and they were absolutely balling their eyes out, they'd sit and talk to them, and they'd calm them down, but they wouldn't do that for mental health patients I don't think' (O' Connor, 2015, p.65)
	Logistics of the Environment	'When they come in here it should be in a private room, I don't want everyone knowing my woes and troubles' (Walker, 2017, p.114) 'I've heard some really horrible stories about A & E' (Taylor, 2003, p.88).
Inner turmoil / Experience	Negative Emotions	'I've learnt to keep my mouth shut because I can say too much' (O' Connor, 2015, p.59) 'I was going back to where I started, I felt confused, I thought 'what were the point of coming to hospital?'' (Horrocks et al., 2005, p. 13)
What is deemed helpful	Regular check ins	'It makes me want to stay and wait, and it makes me want to feel better' (Palmer et al., 2007, p.17)
	Distress recognised	The main thing was that [psychiatrist] did look as if he actually cared, that's it, and he wanted, he really wanted to help me, and so that was a very positive thing' (Hunter et al., 2013, p. 316)

Appendix F – Author Guidelines

1. The Editorial Board invites submissions from across the social sciences and related applied areas, including psychology, sociology, social care, social work, social policy, community development, education, criminology, youth work, family studies, early education and related areas. Proposals for special theme issues are also welcome. While the primary area of focus is Ireland, submissions from other regions are also welcome, particularly those that provide a comparative perspective.

2. Manuscripts may be pre-screened to ensure they fit the aims and scope of the Journal. It is editorial policy that manuscripts are sent to two anonymous peer reviewers. To that end, authors should not put their names or other identifying features on the manuscript.

3. Proposals for special or themed issues are welcome. They should normally comprise at least five related articles of around 5,000 words each, plus an Introduction or Editorial. Suggestions for special/themed issues should be addressed to the Editor in the first instance. A short proposal outlining the proposed theme that you would like to cover should include details of why you feel that this theme is of contemporary interest, an indicative list of potential articles or authors (most of who will have agreed to contribute), and your CV, including recent publications. Once approved, the Guest Editor/s will have responsibility for managing the paper submission and review process and for ensuring the quality of the issue. All published content must be approved through the normal IJASS refereeing and editorial process, and final editorial control remains with the IJASS Editor.

4. Manuscripts must be between 4000-6,000 words in length (excluding References, Tables and Figures).

5. The manuscript should be preceded by an abstract, on a separate page. The abstract should consist of title, and summary of the paper, between 300 and 500 words in length. The abstract should end with three or four key words relating to the content.

6. Manuscripts should be typed on one side of the page, font size 12, double-spaced with wide margins. Manuscripts should be submitted electronically at http://www.arrow.dit.ie/ijass.

7. At the layout and copy editing stage, the Editor reserves the right to make minor style / expression changes to the text.

8. Submission of an article is taken to imply that it has not previously been published and is not being considered for publication elsewhere. This fact should be stated by the author in a covering letter on submission.

9. The covering letter must state the word length of the manuscript (excluding References, Tables and Figures).

10. The American Psychological Association referencing style must be used (as per 6th edition of the APA Publication Manual, 2010). See examples below. References should be placed in alphabetical order at the end of the text. The second line of each entry to the References should be indented by one tab

Appendix G - Letter of Invitation

Donal Moynihan
Trainee Clinical Psychologist
University College Cork
110303349@umail.ucc.ie
086 822 3324
xxth xxx 2018

Mr xxxxxxxx
Xxxxxxxxxx
Xxxxxxxxxxxx

Dear xxxxxxxxxxxx,

Further to your telephone conversation with the crisis nurse from Cork University Hospital/Mercy University Hospital on the x of x, I am writing to you today to tell you some more about my interview project. My name is Donal Moynihan and I am employed by the HSE and undertaking professional training in Clinical Psychology as part of a doctoral programme in UCC.

As discussed, I am interested in gaining a better understanding of why males who engage in self-harm present to the emergency department but do not follow through with accessing follow up assessment and treatment. This would involve you taking part in an interview with me where you can reflect on your experiences of accessing services. This interview is being carried out independently of CUH/MUH and does not affect your usual health care entitlements. It is hoped that services can be shaped better to suit your needs.

Please find enclosed a leaflet with all the relevant information, including supportive services should you wish to contact them.

I will ring in the next few days to have a chat about the project and to see if you would like to participate. In the meantime, should you have any queries, please feel free to contact me at the above number Monday – Friday 9am – 5pm. Please leave a voicemail if I cannot answer and I will get back to you as soon as possible.

Thank you for your help.

Yours sincerely,

Donal Moynihan

Appendix H - Information Sheet and Consent Form

Information sheet for participants

A qualitative exploration of the reasons why males who present to the Emergency Department for self-harm leave before next care recommendations can be made

You are being invited to take part in a research project. Before you decide, it is important for you to know why the research is being done and what it involves. Please take time to read the following information carefully. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

- **What is the project about?**

This project is about the different reasons why males who present to the Emergency Department for self-harm leave before next care recommendations can be made. The project involves conducting interviews with people who have come to hospital following an episode of self-harm. We will interview people after they have come to hospital following a self-harm episode. Taking part will not affect your usual health care entitlements as it is being conducted independently from the hospital by a researcher from University College Cork.

- **What is the aim of the project?**

We hope that, by gathering this information, we can better understand the factors that put a person at risk of leaving of the hospital before they get the help they need and the factors that help to prevent this. It is hoped that services can be shaped to meet people's needs.

- **Why take part in the project? What could be your benefits?**

The benefits of taking part will be to contribute to improved understanding and treatment of self-harm because the findings from this project will be communicated to psychologists and health care professionals. We also hope that this project will benefit participants by giving them the opportunity to speak with a Psychologist in Clinical Training about their self-harm act.

- **What would taking part in the project mean for you?**

Participation in this project is voluntary. If you decide to take part, you will be asked to sign a consent/agreement form that will confirm your decision. You will be asked to take part in an interview with a Psychologist in Clinical Training. The interview involves questions about your life, aspects associated with self-harm and your experience with attending the hospital. You may refuse to respond to one or more questions if you do not feel comfortable doing so. The interview will last about one hour and you are free to end the interview at any time. Before any findings are entered into a report or an academic paper, any details that could be used to identify you will be removed.

The project is voluntary. You are free to withdraw your data up to two months after you complete the interview, even if you have already agreed to take part, and you do not have to provide a reason for not wishing to continue.

- **How will my information be used?**

The information will be anonymous - your name and any identifying details will be removed to protect your privacy. The information you provide will be used to identify some of the reasons that male self-harm patients leave the hospital before recommendations can be made. Once the project

is complete, this data will be compiled and summarised in a publication to disseminate the findings. Before any findings are entered into an academic paper, any details that could be used to identify you will be removed.

❖ **Will my taking part in this project be kept confidential?**

The only reason the researcher would break confidentiality is if it became apparent that you were likely to harm yourself or harm another person. In this situation the researcher would be obliged to contact a third party. Before contacting a third party, the researcher will first speak with you, explaining that in the interest of your safety or other people's, it is necessary to communicate with another party regarding your behaviour or information you have given. If I learn that a vulnerable person (child/adult/older adult) is being abused or is at risk of being abused I am obliged to notify the relevant agency or if I am working with an adult who discloses that they were a victim of childhood abuse (even if they do not disclose any other details about it) I am obliged to notify the relevant agency.

Any information you provide will be made anonymous as well as processed and stored in accordance with national and European data protection laws. This means that we have put in place measures and procedures to make sure that your information remains secure.

- Any information which is submitted to us will be stored on secure servers.
- All electronic files will be encrypted and password protected
- Your name, date of birth and any other information that could identify you will be removed from paper-based records and stored separately from interview information.
- Your contact details will be kept on electronic files and will be encrypted and password protected to which only the local core project team will have access and will not be used for any other purposes.

Any information which you provide will only be used for the purposes of this project. If you would like to access your information or if you would like your information to be deleted up to 2 months after the interview has taken place you can contact the research team at the contact details below.

❖ **What will happen to the results of the project?**

The information from the project will be analysed by the researcher in a way that allows us to identify reasons why male self-harm patients may wish to leave the hospital before recommendations. We will then use findings in an anonymised way in publications and presentations to share the information with healthcare professionals, psychologists and the wider community

❖ **Who is organising and funding the project?**

The project is being run as part of the fulfilments for a Doctorate in Clinical Psychology at University College Cork. More information about the project is available from: Donal Moynihan

Tel.: 086 822 3324 (Monday – Friday; 9am-5pm; Please leave a voicemail if I cannot answer and I will get back to you as soon as possible) **Email:** 110303349@umail.ucc.ie. Donal is under the supervision of Daniel Flynn, Principal Psychology Manager, and Dr Sharon Lambert, UCC.

Consent form for participants

-The project has been fully explained to me. I have had the opportunity to ask questions concerning all aspects of the project.
-I am aware that participation is voluntary and that I may withdraw at any stage. I am aware that my decision not to participate or to withdraw will not restrict my access to health care services normally available to me.
-Confidentiality of records concerning my involvement in this project will be maintained in an appropriate manner.
-I, the undersigned, hereby consent to taking part in an audio recorded interview exploring self-harm and reasons why males may leave the hospital before recommendations.
-I allow my anonymised interview data to be used as part of the research project.
-I have received a copy of this consent form for my records.
-I understand that if I have any questions concerning this research, I can contact Donal Moynihan.
-I understand that the study has been approved by the Ethics Committee of the School of Applied Psychology, University College Cork.

Please tick yes or no

I have read and understand the study information sheet: **yes** ☐ **no** ☐

I agree to take part in the interview: **yes** ☐ **no** ☐

I agree to allow the interview to be audio recorded: **yes** ☐ **no** ☐

I agree to allow my interview data to be part of the research project write-up: **yes** ☐ **no** ☐

I understand that my anonymised data will be stored in an encrypted and pass worded file: **yes** ☐ **no** ☐

Contact details of next of kin
Name: _____ **Contact Number:** _____

Contact Details of GP:
Name: _____ **Contact Number:** _____

Chief Investigator Signature: _____

Signature of Participant: _____

Date: _____

Appendix I - Support Numbers

Support and Treatment Services in the Cork Area

Helplines

Samaritans **LoCall 1850 60 90 90**

Samaritans offers non-judgmental emotional support to those in distress. The Cork branch of the Samaritans is located at 7-8 Coach Street near the back of the Mercy Hospital in Cork City. The helpline offers 24-hour support, you can drop into the branch on Coach Street between 9am and 10pm every day, or you can send an email to jo@samaritans.org.

National Counselling Service **Freephone 1800 477477**

This service was set up by the HSE to provide counselling, particularly to those who experienced abuse in childhood. The helpline operates Wednesday to Sunday from 6.00pm to 10.00pm. To arrange face-to-face counselling session, see the entry below.

AWARE **LoCall 1890 303 302**

AWARE is an organisation that provides non-judgmental support to those experiencing depression and to their family and friends. The helpline is open seven days a week from 10am-10pm. From Thursday to Sunday, the helpline operates from 10am-1am.

Counselling Services

National Counselling Service **Freephone 1800 234 116**

This service was set up by the HSE to provide counselling, particularly to those who experienced abuse in childhood. To arrange a counselling session, ring the freephone number above. The Cork centre is located at Harbour Counselling, Penrose Wharf in Cork City and is open 9.00am to 5pm.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Community Alcohol & Drug Counselling Services

These services are directed at those experiencing problems with alcohol or drugs. The Cork City service is located at 10 Church Street, off Shandon Street, and you can arrange an appointment by phoning (021) 421 2382. The Skibbereen office can be reached by phoning (028) 23456.

Support Groups

Aware
Helping to Defeat Depression

AWARE runs support groups for people affected by depression. These are held on Tuesday at 8pm in Iniscarraig House on Western Road in Cork City, Tuesday at 8pm in the James O'Keefe Memorial Building in Newmarket and on Thursday at 8pm in the Le Chéile Family Resource Centre at Mallow Community Campus. For information on support groups, contact the regional office on 066 719 4713.

Health Services

In an emergency situation, ring 999 or 112

Emergency departments

Cork City

Mercy University Hospital, Grenville Place, Cork	021 4935241
Cork University Hospital, Wilton, Cork.	021 454 6400
South Infirmary Victoria University Hospital	021-4926175

Cork County

Mallow General Hospital, Limerick Road Mallow	022 21251
Bantry General Hospital, Bantry	027 50133

Out of Hours Primary Care

South Doc General Practitioner Co-op	1850 33599

Appendix J - Interview Schedule

Introduction—including explaining study, answering questions and taking consent.

How long has it been since your last visit to the emergency department for self-harm? What were the circumstances surrounding it?

How did you feel about seeking medical help/attending the emergency department? (Focus on last presentation and then broaden to previous episodes if necessary) Did someone encourage you to go or was it your own decision?

What were your expectations of treatment? Were they met? Were you told about what the process would be after you met triage nurse?

What do you believe impacted on you wanting to leave the ED?

Did waiting at the ED remind you of any other experiences in your life?

Did the environment of the ED have an impact on your decision? What were you thinking/feeling at each stage of the environment?

Did your interaction with staff have an impact? How did you feel on meeting staff?

What would have been needed to help you stay?

How would you feel about going back to the hospital for self-harm if you had to? What would you change about the experience if you could?

Debrief and leave useful numbers with participant

Appendix K - Ethical Approval

University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Coláiste na nEalaíon, an Léinn Cheiltigh agus na nEolaíochtaí Sóisialta
College of Arts, Celtic Studies and Social Sciences

Scoil an Síceolaíochta Feidhmí
School of Applied Psychology

University College Cork,
Cork, Ireland.

T +353 (0)21 490 4551 / 4552
E infoapsych@ucc.ie
http://www.ucc.ie/en/apsych/

12th April 2018

Dear Donal,

A qualitative exploration of the reasons why males who present to the Emergency Department for self-harm leave before next care recommendations can be made

Thank you for your resubmission. Based on your written proposal and further clarification and discussion during the meeting, the decision of the panel was:

- **Pass, conditional on required revisions**

In formulating a revised submission please attend to the following issues raised by reviewers on the current proposal:

- Clarify opt-out and opt-in: request that the crisis nurse gets their agreement to opt in – build this in to their phone call. That way you have an explicit opt-in. **The nurse's call should also seek consent for your phone call to them a few days later**
- Time limit the withdrawal option – see page 6 and page 11, this is currently open ended and needs to be tightened. **The two month limit should also be in the consent form**
- Tighten up the limits as to when participants can call the work mobile to make it more contained. Have clear boundaries around this. **I do not think this has been done**

Every best wish with making these revisions.

Yours sincerely,

Dr Mike Murphy
Chair Clinical Psychology Research and Ethics Panel

Appendix L - Analysis Example

Stage 1: Initial reading and brief notes

The extract in Table 1 from Maurice demonstrates the first stage of the analysis which involved a close reading of the text and initial exploratory comments. Descriptive aspects of the transcript are noted with plain text. Underlined text displays more interrogative and conceptual notes and can link to the literature on the topic. Comments on the use of language are highlighted by italicised text and show how the choice of language could point to wider issues.

Table 1. First stage of analysis

Extract from interview	Exploratory comments
Maurice: I was sitting there twiddling my thumbs. I kept getting up pacing. I stood there at one point banging my head off the wall hoping they'd come over to me. One nurse seen me. They kept walking past me and when I went in first they were like 'you're next to be seen to see the psychiatrist' and then 4 hours later I was still sitting there. Then all those crazy thoughts came back and I felt really anxious. Like 'what are they doing? They're not going to help you. Just leave. Go away and do it again' So then I left.	Restless/bored/felt out of place Looking to be noticed, couldn't express needs verbally, physical expression of communication, *Like well-known saying, felt his efforts were hopeless and ultimately fruitless* Invisible, Unmet expectations Did he feel powerless to thoughts coming back of their own accord? Acknowledges connection between thoughts and emotion Possibly felt unworthy of care when not 'seen'. Suspicious of staff Return to risky thoughts *Understood his thoughts as demands which had to be followed*

Stage 2: Development of initial themes

Each transcript was coded in depth. In looking for emergent themes, the next step is to map the relationships, patterns and connections between exploratory notes. This represents a part of the hermeneutic circle as the

original whole of the interview becomes a set of parts to be analysed in the context of the full transcript. However, this comes back together at another level at the final stage of the analysis write up. The themes reflect both the participant's original words and the analyst's interpretations. Themes from the stage 1 extract include; *Feeling Invisible* which refers to the nurses walking past him; *Powerless to Thoughts* which refers to his use of language and internal monologue, and *Lack of Information* which refers to process of waiting for the psychiatrist. Therefore, themes bring together a range of understandings from the participant and analyst.

Stage 3: Creation of higher order themes

The next step is to develop how the themes fit together. Table 2 below demonstrates a superordinate theme and the initial themes organised within it.

Table 2. Superordinate theme

Maurice: Waiting in the shadows
Invisible
Isolation
Put out of the way
Trapped
Abandoned
Needing attention
Punishment
Need to talk to someone
Uncertainty

Abstraction was used here to group like with like and develops a new name for the cluster. It is also an example of a functional superordinate theme as it pertains to the emotional impact that not being acknowledged had for him.

Stage 4: Creation of master list of themes, with quotations

The final step for each transcript was to develop a master list of themes. This is utilised in the next stage of the analysis to look for patterns across cases. Table 3

is an abbreviated section of the master list for Maurice and demonstrates the superordinate theme *Waiting in the shadows.*

Table 3. Master list

Themes	**Line**	**Quotation**
Waiting in the shadows		
Feeling invisible while waiting	229-230	You're only like a shadow in the background. They're just walking past you.
Isolation	66-67	I could be in a room with a hundred people and I'd feel alone and not even in the room
Put out of the way	75-76	they could clearly see my face was all cut and my hands and stuff and they were like 'we'll put him in the corner, once he's cleaned up he's grand'
Abandoned	150-151	Like I was left sat there for hours not knowing if I was going to be talking to someone or anything
Needing attention	120-121	ya trying to get their attention. Like they were looking at me banging my head off the wall like

With comparison to table 2, it is apparent that some of the initial themes are not present or have been changed slightly. Some themes emerged as better fits for other categories e.g. *uncertainty* was thought to be more suitable under the superordinate theme of *Uncertainty without shared information.* Themes can also become unnecessary as it is deemed they represent the same concept as another or due to the lack of significance within the individuals transcript e.g. *trapped*.

Stage 5: Creation of a group master list

Creating a group master list involves similar processes as in the individual cases. However it is hoped to establish connections between cases and also to demonstrate unique idiosyncratic instances. The theme *Safety and other service users* is a superordinate theme which demonstrated aspects of most of the participant's experiences. The subtheme *An element of fear* is more specific and is

portrayed in various ways by the different participants e.g. Eoin speaks about seeing others speaking and wondering is it about him, while Terry focuses on the internal aspects of the other individuals. Fear of other service users is an underlying issue for both which impacted on them wanting to leave A & E.

Table 4. Group theme

Superordinate theme: Safety and other Service Users			
Subtheme	*Brief Description*	*Representation*	*Key Quotes*
An element of fear	Fear of other service users who are waiting; uncertainty regarding their intentions and urges	5 participants	*There's loads of people around you. You're thinking to yourself 'what's my next move?'* (Luke) *You're afraid of your life. Afraid to look left and right. You could see people talking over there and think they're talking about you.* (Eoin) *There's an element of fear and you're trying to deal with what's going on in your own head but you definitely don't have a clue what's going on in their head, you know* (Terry)

Appendix M - Distribution of themes

Superordinate theme	**Safety and other service users**			**Waiting in the shadows**		**A compounding of distress**		**Expectations from experience**		**Client- clinician relationships**	
Subtheme	***Putting others at risk***	***An element of fear***	***Feeling exposed***	***A shadow in the background***	***Risky thoughts; They'd eat you up***	***Like mental health is not an issue***	***A monkey in a cage***	***Inpatient; not going down that road again***	***A & E; knowing the procedure***	***Uncertainty without shared information***	***A questionable questioning style***
Michael	X	X		X					X	X	X
Luke	X	X	X	X	X	X	X		X		X
Maurice	X			X	X			X	X	X	X
Niall		X	X	X				X	X		
Terry		X	X	X	X	X	X	X		X	X
Eoin	X	X	X		X			X	X		X

Appendix N - Reflexive statement

Around the time of deciding on a research topic I struggled to settle on something that felt worthwhile, and at the same time, feasible. My previous experiences greatly influenced my interest in the area of self-harm and no doubt impacted on the research process. While completing my Master's we had a workshop on self-harm and what struck me most was the level of it that was happening in the area by young men around the same age as me. I saw this in clinical practice in the years to follow and began to get a picture of how difficult it was for some men to communicate such distress. This was saddening, but it instilled a hope that more could be done. Reading about the number who leave A & E every year before receiving the appropriate assessment or next care recommendations started a line of enquiry in the area.

With some limited quantitative data available, I was interested in developing my qualitative research skills and believed it would add more to our understanding. IPA appeared appropriate and complemented my belief that Service Users are experts by experience. I wanted to understand what their experience was in the lead up to leaving the A & E.

The ethics panel presented the first obstacles and understandably were concerned regarding contacting people who had already 'opted-out of services' in a way. However, those who took part were very passionate regarding their views on the services and reported feeling empowered having a voice that may help others who could be in the same situation as themselves. Recruitment of this difficult to reach population was another issue raised by the panel

Recruitment proved to be very frustrating and hopelessness inducing at times when participants did not attend or when there were long periods without even an

opt-in. However, I learned a lot about the research process and to have patience regarding the outcome. I was humbled to bear witness to the stories of the men who chose to take part.

At times during the interviews I struggled to refrain from engaging in a sort of therapy. Where appropriate I gently challenged some viewpoints, but was mindful of allowing them to share their experience for what they believed it to be in order to maintain the research integrity. After a few of the interviews we spent some time discussing possible referral routes so they could engage with community services.

The process of analysis was time consuming and challenging. With such an emotive topic the close examination of the transcripts proved difficult at times, especially following the death of a colleague by suicide. I utilised supervision to move through this process and was careful to reflect on my interpretations and beliefs due to my own experience.

With regard to the interpretive aspect of IPA, it took some time to leap from the more concrete coding and understandings to trusting in my own engagement with the material. I wanted to make sure I represented what the participants said during the interviews but was also aware of the value of another interpretive lens. It was a fine line to walk at times.

I learned a lot about myself and services while carrying out this research. It was an enriching experience on professional and personal levels and I hope it will have an applied clinical impact.

Appendix O – COREQ

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:
Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Inter viewer/facilitator	Which author/s conducted the interview or focus group?	53
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	55
3. Occupation	What was their occupation at the time of the study?	55
4. Gender	Was the researcher male or female?	55 55
5. Experience and training	What experience or training did the researcher have?	55
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	53
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	53
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	131

Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	53
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	52
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	52
12. Sample size	How many participants were in the study?	52
13. Non-participation	How many people refused to participate or dropped out? Reasons?	52
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	52
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	N/A
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	52
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	124
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	N/A
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	53
20. Field notes	Were field notes made during and/or after the interview or focus group?	53
21. Duration	What was the duration of the inter views or focus group?	53
22. Data saturation	Was data saturation discussed?	53
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A

Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	54
25. Description of the coding tree	Did authors provide a description of the coding tree?	126
26. Derivation of themes	Were themes identified in advance or derived from the data?	54
27. Software	What software, if applicable, was used to manage the data?	N/A
28. Participant checking	Did participants provide feedback on the findings?	N/A
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	57- 92
30. Data and findings consistent	Was there consistency between the data presented and the findings?	57-92
31. Clarity of major themes	Were major themes clearly presented in the findings?	57-92
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	57-92

Appendix P - Author Guidelines

About the Journal

Archives of Suicide Research is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims and Scope for information about its focus and peer-review policy.

Archives of Suicide Research accepts the following types of article: original articles.

Peer Review and Ethics

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Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper. There are no word limits for papers in this journal.

Style Guidelines

Submissions to Archives of Suicide Research should follow the style guidelines described in Publication Manual of the American Psychological Association (6th ed.). Merriam-Webster's Collegiate Dictionary (11th ed.) should be consulted for spelling.

Formatting and Templates

Papers may be submitted in Word or LaTeX formats. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

References

Please use this reference guide when preparing your paper. (Link to APA guidelines)

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